AN
INTEGRATED DISTRICT MODEL FOR MATERNAL, NEONATAL, AND CHILD HEALTH:

A DECENTRALIZED HEALTH SYSTEMS APPROACH TO REDUCING MATERNAL AND NEONATAL MORTALITY

Indonesia Health Services Program

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Table of Contents

List of Tables

List of Figures

ACRONYMS

AIDS : Acquired immune deficiency syndrome
AMTSL : Active Management of the Third Stage of Labor
ANC : Antenatal care
APBDes : *Anggaran Pendapatan dan Belanja Desa;* village budget
APN : *Asuhan Persalinan Normal*; Basic Delivery Care
ARI : Acute Respiration Infection
AusAID : Australian Government Overseas Aid Program
Bappeda : *Badan Perencanaan Pembangunan Daerah;* Local Development Planning Board
BCC : Behavior Change Communications
BF : Breastfeeding
BEONC : Basic Emergency Obstetric and Neonatal Care
Bidan Delima: IBI's program for private sector midwives
Bidan di desa: village midwife
BPD : *Badan Permusyawaratan Desa;* legislative branch of village government
Bupati : head of the district
CEONC : Comprehensive Emergency Obstetric and Neonatal Care
CHC : Community Health Committee
CSR : Corporate Social Responsibility
CTS : Clinical Training Skills
CTU : Clinical Training Update
DHO : District Health Office
DPRD : *Dewan Perwakilan Rakyat Daerah;* Local legislative body
DTPS : District Team Problem Solving
EMT : Emergency Management Training
EONC : Emergency Obstetric and Neonatal Care
ER : Emergency Room
GOI : Government of Indonesia
HIV : Human Immunodeficiency Virus
HSP : Health Services Program
IAKMI : *Ikatan Ahli Kesehatan Masyarakat Indonesia;* Indonesian Public Health Association
IBI : *Ikatan Bidan Indonesia;* Indonesian Midwives Association
IDAI : *Ikatan Dokter Anak Indonesia;* Indonesian Pediatric Association
IDHS : Indonesia Demographic and Health Survey
IMCI : Integrated Management of Childhood Illness
IMNCH : Integrated Maternal, Neonatal and Child Health
IPC-C : inter-personal communication and counseling
JICA : Japan International Cooperating Agency
JNPK : *Jaringan Nasional Pelatihan Klinik;* national training network center
Kader : health volunteers
KMC : Kangaroo Mother Care
LAM : Local Area Monitoring
LAMAT : Local Area Monitoring and Tracking

LBW : low birth weight
MDG : Millennium Development Goal
MMR : Maternal Mortality Ratio
MNCH : Maternal, Neonatal and Child Health
MNERC : Maternal Neonatal Emergency Room Care
MOH : the Ministry of Health
MPA : Maternal and Perinatal Audit
MPS-CS : Making Pregnancy Safer and Child Survival Strategy
Musrenbang : *Musyawarah Perencanaan Pembangunan;* Development Planning Forum
NGO : Non-Governmental Organization
NMR : Neonatal Mortality Ratio
OJT : On-the-Job Training
ORT : Oral Rehydration Therapy
P2KS/P : *Pusat Pelatihan Klinik Sekunder/Primer*; Provincial/District training centre
P4K : *Program Perencanaan Persalinan dan Persiapan Komplikasi*; the Birth Preparedness and Complication Readiness Program with sticker, an MOH program
PerBup : *Peraturan Bupati;* Bupati Decree
Perdes : *Peraturan Desa;* Village regulation
PerDa : *Peraturan daerah;* Local regulation
Perinasia : *Persatuan Perinatologi Indonesia;* Indonesian Perinatalogists' Association
PHO : Provincial Health Office
PKK : *Pemberdayaan dan Kesejahteraan Keluarga; a* national women's group promoting family welfare and empowerment
PMTCT : *prevention of mother-to-child transmission*
PNPM : *Program Nasional Pemberdayaan Masyarakat;* National Community Empowerment Program
POGI : *Perkumpulan Obstetri dan Ginekologi Indonesia;* Indonesian Obstetric Association
Pokja IV : *Kelompok Kerja 4*; working group on health in PKK
Polindes : *Pos Bersalin Desa;* Maternity clinic at the village level
PONED : *Pelayanan Obstetri dan Neonatal Emergensi Dasar;* see BEONC
PONEK : *Pelayanan Obstetri dan Neonatal Emergensi Komprehensif;* see CEONC
Posyandu : *Pos Pelayanan Terpadu;* community-based health service
PPGDON : *Pertolong Pertama Gawat Darurat Obstetri dan Neonatal;* First Aid to Obstetric and Neonatal Emergency
PPNI : *Persatuan Perawat Nasional Indonesia;* Indonesia Nurses Association
PTP : *Perencanaan Tingkat Puskesmas*; Puskesmas level planning
Puskesmas : *Pusat Kesehatan Masyarakat*; Sub-district health facility
Pustu : *Puskesmas Pembantu*; Assisting *Puskesmas*
PVO : Private Voluntary Organization
QUAPEC : Quality and Access to Perinatal Emergency Care
SK : *Surat Keputusan*; decree
STI : Sexually Transmitted Disease

TT2 : Second Tetanus Toxoid Immunization
UNICEF : United Nations Children's Fund
USAID : United States Agency for International Development
WHO : World Health Organization

INTRODUCTION

Over the last 10 years there has been momentous progress in reaching consensus on how to reduce maternal and neonatal mortality, which accounts for 40% of all child deaths. While this historic consensus recognizes that there are no quick fixes outside of the health system, there is now solid evidence to demonstrate that maternal and neonatal deaths will be significantly reduced if all women receive access to: 1) family planning; 2) skilled care during pregnancy, delivery, and post-partum; and 3) emergency obstetric care when complications arise. Despite this agreement on what to do, progress has lagged as a result of weak political commitment and a lack of visible and validated integrated implementation models. With the target date of 2015 for the Millennium Development Goals now only five years away, there has been a visible show of increased political commitment from governments across the world. Therefore, there is now an even greater need for the dissemination of effective implementation models that can be replicated with local adaptations, and scaled-up for impact.

This report presents a model and rationale for implementing an integrated maternal, neonatal and child health (MNCH) program based on the experience of the USAID-funded Health Services Program (HSP) in Indonesia, working in collaboration with the Indonesian Ministry of Health and selected district governments. The model is essentially a methodology for better programming of the various elements of the existing system in order to more effectively reduce maternal and neonatal mortality; its key characteristic is integration. For the purposes of program short hand, and for the purposes of this report, it is referred to as the Integrated Maternal, Neonatal and Child Health (IMNCH) Model. While the details of the IMNCH Model are specific to the Indonesian system, this report aims to provide wider lessons and thereby responds to a critical need for guidance in programming decentralized health services, a process that is taking place so many countries.

Decentralization has seen the responsibility for planning, financing, delivering and monitoring health services pass from central health ministries to local authorities; in the case of Indonesia, it is district and municipal governments that hold the primary responsibility for health care. A number of actors who have little knowledge or experience with healthcare implementation, including mayors, members of local parliaments, village authorities and community members, civil society leaders, and national and district government officials from diverse agencies, must collaborate in order to allocate resources and monitor outcomes. In working with Indonesian stakeholders and drawing on their knowledge of all the various agencies involved, HSP has helped to identify existing policies, tools, and processes that can be used at the district level to facilitate a multi-stakeholder and multi-sector process for overcoming the most serious barriers to reducing maternal and neonatal mortality and morbidity in Indonesia.

Support for strengthening critical elements of the local health system and in conceptualizing and testing the IMNCH approach were conducted in collaboration with the Indonesia Ministry of Health and district governments under a Cooperative

Agreement awarded to JSI Research & Training Institute, Inc. from April 2005 to September 2010. HSP was designed to reduce maternal, neonatal, and child mortality through an integrated assistance package of evidence-based interventions that could be made available to districts as well as a system for replicating the delivery of that package widely which maximizes the chance of national impact as quickly as possible through technical assistance and collaborative support to government counterparts, civil society partners, NGOs and communities. The project design emphasized rapid replication and scale up of existing interventions. The original package was designed around five strategic approaches, all focused on decentralized district provision of healthcare: 1) integration of technical components; 2) strengthening of decentralized health systems and services; 3) leveraging of funds from other donors; 4) harnessing of NGOs and PVOs; and 5) engaging the private sector.

The collaborative approach facilitated by HSP provides a model for districts and municipalities to implement a comprehensive and integrated strategy for reducing maternal, neonatal, and child mortality. The model promotes collaboration among different levels of government, multiple governmental, nongovernmental, private sector, and civil society organizations, communities and households to undertake the actions necessary to reduce maternal, neonatal, and child mortality, including:

1. allocation and planning of financial, infrastructural, and human resources;
2. capacity building in planning, management, and evidence-based clinical practices;
3. data collection, analysis, and application for planning, surveillance, and quality improvement; and
4. strengthening of critical health systems, including logistics, referral, and supervision.

HSP took the approach of strengthening the Indonesian MNCH system, using the existing components of that system, both clinical and governmental. Although it was not envisaged in the original design, HSP also supported the MOH to revise and update a number of the key guidelines and tools or to develop new ones in places where gaps had been identified. In supporting these revisions, HSP played a catalytic role by bringing together diverse actors, led by the relevant health professional organizations and the MOH, with the result that Indonesian technical policy was brought up-to-date with international best practice.

In supporting this work, HSP also helped to strengthen the enabling environment for the envisaged scale up. For example, by supporting the revision of the District Team Problem Solving Approach, an evidence-based planning tool was taken from its origin as a project planning instrument to become a core plank of the annual district health planning process. This in turn laid the groundwork for districts to be able to plan for and implement the clinical guidelines also updated with HSP support.

Whether supporting revisions to technical materials or supporting processes for implementation, HSP fostered a systems approach of working with the relevant Indonesian partners to ensure that they understood their role and function in relation to

the intervention. For most of the activities, HSP was mindful of not adding to the system, but of helping partners to clarify existing mandates and responsibilities for action. This approach also helped to identify prospects for ongoing financial support; HSP supported organizations to ensure activities were understood as part of their core function and supported the development of plans and budgets for ongoing implementation. All kinds of partners were included in this approach, whether district level technical departments, local politicians, NGOs, professional organizations or even teams of village volunteers. In addition to helping organizations to plan for activities within their existing capabilities, HSP supported organizations to find sources of eligible funding including GOI mainstream development funding, funds and in-kind support available under corporate social responsibility and by leveraging replication under programs supported by other international development partners including CARE, UNICEF and AusAID.

At the height of program operation, HSP supported selected, locally prioritized, activities in 31 districts across six provinces. An external evaluation in 2008 recommended that HSP receive a twelve-month extension to focus more narrowly on one or two districts in order to support implementation and documentation of the full model district-wide. From 2009 to 2010, HSP focused on supporting the implementation of the integrated model in Malang and Pasuruan, two rural districts in East Java.

The description of the integrated model presented in this report is based largely on the experience of HSP in supporting its implementation in Malang and Pasuruan in the final phase of the program, but also draws on the lessons drawn from collaboration with partners at the national level and in the other 29 districts where HSP worked.

While HSP sought to support and strengthen the existing system, the reality in Indonesia is that the administrative landscape of decentralized governance is not always clear. Regulations and processes developed by multiple national ministries may have bearing on a single element of service delivery. This has proved one of the difficulties for districts, but has also provided opportunities for districts to negotiate approaches to implementation. The IMNCH Model incorporates some of the lessons learnt from these partners. HSP acknowledges the creativity and dedication of many counterparts in finding ways to deliver quality maternal, neonatal and child health services to their populations, and hopes this report will help them to improve their implementation into the future.

ORGANIZATION OF THE REPORT

The next section, *Situational Analysis of MNCH in Indonesia*, provides an overview of progress towards reducing maternal, neonatal, and child mortality in Indonesia. It also describes some of the obstacles the IMNCH Model addresses in order to accelerate the reduction in mortality and morbidity.

The following section, *The IMNCH Model: A Pathway to Care and Survival*, describes the Pathway to Care and Survival and shows how the Indonesian IMNCH Model corresponds to this approach. It describes how to bring together evidence-based

practices, health governance, political commitment, and social mobilization to reduce barriers in the health system and increase the likelihood that women, newborns, and children will receive appropriate and timely healthcare.

The next section, the *IMNCH Model: a Decentralized Health Systems Approach*, describes the structure and implementation of the model, illustrated through the experience of HSP support in Malang and Pasuruan districts. This section highlights each component of the model by describing the specific barriers it addresses, the specific processes supported under the component, and what changes occurred as a consequence of implementation in the two districts.

The final section provides recommendations for adaptation, replication, and scale-up of the model in Indonesia and elsewhere. The most important elements of the scale-up are that the majority of resources are already within the system – whether provided by national, provincial or district governments – and the tools and guidelines are institutionalized within the GOI – whether at the level of national policy, in district legal frameworks, in sub-national health offices, or community organizations. Therefore, replication and scale-up require only minimal focused technical assistance, training and facilitation from external sources.

SITUATIONAL ANALYSIS OF MNCH IN INDONESIA

Since the mid-twentieth century, there has been significant progress towards improving the health of mothers, newborns and children, and expanding health care interventions on a scale previously unimaginable. Globally, under-5 child mortality fell from 159.3 per 1,000 in the late 1950s to 70.4 in the late 1990s, with marked declines since the 1970s due to decreases in death from diarrhea and vaccine-preventable diseases (Millennium Project, 2007). Compared to 16 million child deaths that occurred in 1970, only 7.7 million are expected to occur in the world in 2010 (Rajaratnam et al, 2010). Similar trends pertain to maternal mortality. Worldwide, MMR decreased from an estimated average of 422 in 1980 to 251 in 2008 (Hogan et al, 2010).

The Millennium Development Goals

The MDGs have provided valuable benchmarks both for understanding the MNCH situation, setting programmatic targets, and tracking progress, both globally and at the country level for improving MNCH between 1990 and 2015.

- Goal 4: Reduce child mortality by 2/3
- Goal 5: Reduce maternal mortality by 3/4

The averages mask wide disparities in maternal, neonatal and child mortality among countries. Access to basic care for mothers, newborns and children remains a significant challenge in the developing world, presenting significant challenges to meeting the MDGs. Millions of women, newborns and children are still dying every year around the world, 99% of them in low- and middle-income countries (Sines, Tinker & Ruben, 2006). Worryingly, progress against lowering maternal, neonatal and child mortality has slowed in recent years and even reversed in the poorest parts of the world. As of 2008, only 23 countries were on track to achieve the MDG of reducing the MMR by 75% between 1990 and 2015 (Hogan et al, 2010). While declines in child

mortality are slightly better, the rate for developing countries between 1990 and 2010 was also behind the MDG target (Rajaratnam et al, 2010).

National-level statistics also hide deep inequalities within countries, where the burden of morbidity and mortality is skewed toward poor, remote, and disempowered populations. Child mortality among the poorest fifth of the world's population, for example, has tended to drop at only half the rate of the general population (Millennium Project, 2007). Differences in neonatal and maternal outcomes are evident according to differences in income, residence (rural or urban), race, ethnicity, and sex (for neonatal outcomes only). For instance, women in the wealthiest quintile are considerably more likely than women in the poorest quintile to use a skilled provider when giving birth; by a factor of 23 in Chad, 14 in Bangladesh, and 10 in India (ibid). Some of the disparity in morbidity and mortality that is attributed to income may be due to greater environmental hazards or less access to services in poor areas, but sharp inequalities remain even between rich and poor people living in the same area (ibid).

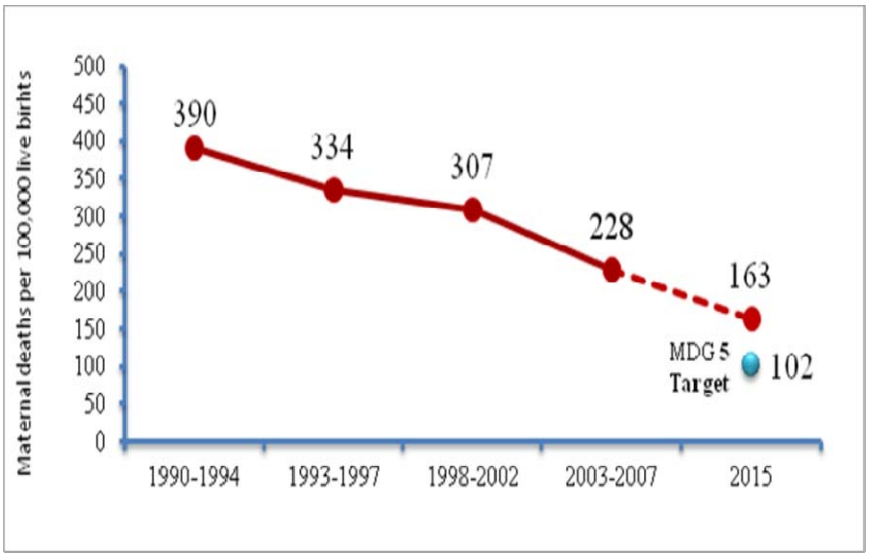


Figure 4: Maternal Mortality Ratio, Indonesia 1990-2015

A. Epidemiology of Maternal and Child Mortality in Indonesia

Indonesia went from sub-Saharan African levels of poverty and social development indicators in the 1960s to those of a middle-income country by the late 1990s. Over the same period, the epidemiology of maternal, neonatal and child mortality has reflected global trends, with broad gains during the second half of the twentieth century followed by stagnating progress in key areas moving into the twenty-first. This uneven progress indicates that MNCH remains a significant challenge in Indonesia.

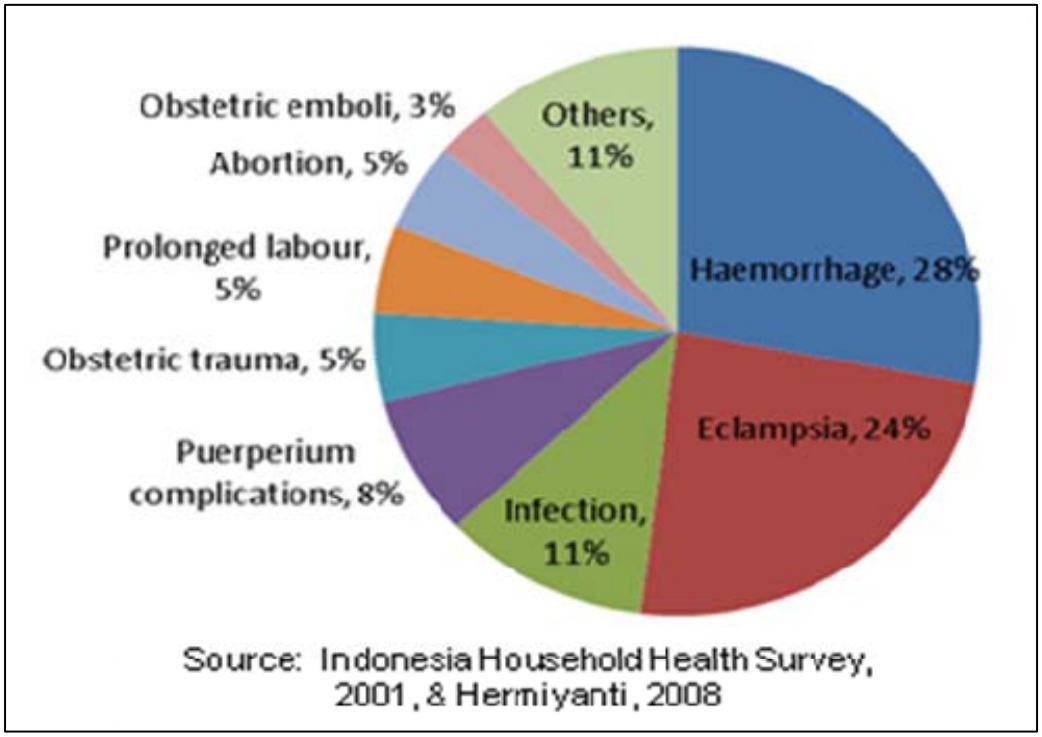


Figure 5: Causes of Maternal Deaths, Indonesia

Maternal mortality remains among the highest in the Southeast Asia region,[1] and there are signs that progress has slowed since the 1990s. While national statistics indicate that the MMR declined from 390 per 100,000 live births in the early 1990s to 228 during the most recent measurement period, the current rate of decline is insufficient to achieve the MDG target of 102.

As with maternal death and morbidity globally, national estimates of rates and causes of maternal death obscure important socio-demographic differences. In 1993-1997, women in the lowest wealth quintile compared to women in the highest quintile were almost four times as likely to experience a maternal death, and this gap has increased 2.5-fold from 1990-1994 (Figure 3). Sub-national studies of districts in West Java in 2004-2005 estimated a maternal mortality gap of 479 per 100,000 in rural areas to 226 in urban areas (Ronsmans, Scott, & Adisasmita et al, 2009), and gap of 706 per 100,000 among the poorest income quartile to 232 among the richest (Ronsmans, Scott S, & Qomariyah et al, 2009).

The Ministry of Health's ***Making Pregnancy Safer National Strategy Plan***, ***2001-2010*** analyzes how weaknesses in the response of the health system contribute to maternal mortality. The main causes of maternal death in Indonesia are hemorrhage, infection, eclampsia, prolonged labor and abortion complications. Hemorrhage, due mostly to

[1] As of 2008, only 3 of 12 SE Asian countries had an MMR higher than Indonesia: Cambodia, East Timor, and Laos (Morgan et al, 2010).

retained pieces of the placenta, is a significant cause of unnecessary deaths, mostly due to inadequate management of the third stage labor. Similarly, maternal deaths from infection are an indicator of poor prevention and management of infections. Meanwhile, maternal deaths from abortion complications are an indicator of unmet need for family planning leading to unwanted pregnancies. Additionally, the percentage of deliveries with an interval of less than 24 months also contributes to high levels of maternal and neonatal morbidity and mortality (MOH 2001).

Under-five mortality rate, at 34 per 1,000 live births as of 2006, appears to be on track to meet the MDG target of 30 by 2015, with under-5 mortality falling by 40% between 1980 and 1997 (Kristiensen & Santoso, 2006, p. 248-249). Yet this result masks the fact that neonatal mortality is not falling fast enough.[2] Between 1986 and 2002, early neonatal mortality in Indonesia decreased by an average of 3.2 percent annually, but deaths on the first day of life did not decrease significantly during this period, indicating problems in neonatal care (Hall et al, 2009). Overall, the current rate of decline of the NMR is off-track for meeting national targets and may compromise the achievement of the MDG target for under-5 mortality.

As with other health indicators, the burden of neonatal mortality varies along socio-demographic lines. Neonatal mortality is highest in rural regions, among women with low education and in the poorer wealth quintiles. Rates also vary by province, ranging from 14 per 1,000 live births in Nanggroe Aceh Darussalam, Central Java and Bali, to 39 and 46 per 1,000 in South Kalimantan and West Sulawesi (IDHS, 2007).

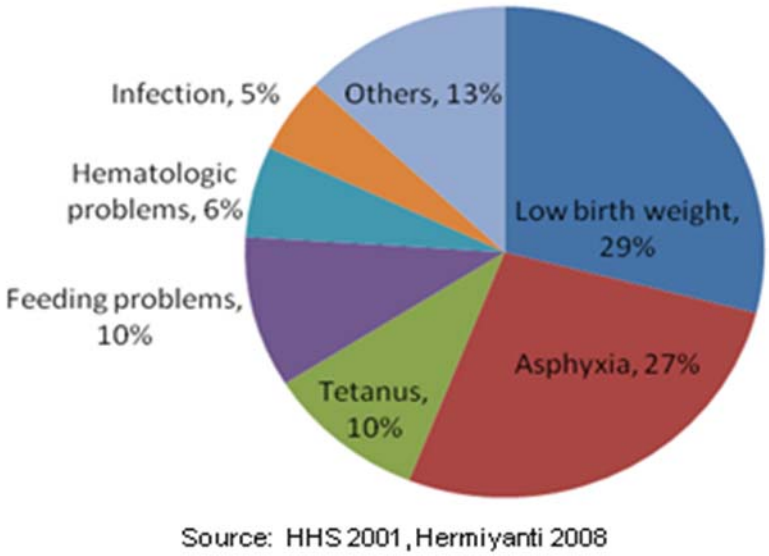


Figure 6: Causes of Neonatal Deaths, Indonesia

There are six key evidence-based interventions for newborn health, which could prevent an estimated 72% of newborn deaths globally; tetanus toxoid immunization, skilled birth attendance, access to emergency obstetric care, and immediate and exclusive

[2] Countdown 2015, Indonesia Country Profile 2008. Available at: http://www.countdown2015mnch.org.

breastfeeding. Scaling-up coverage of a similar package of evidence-based interventions could avoid an estimated 63% of all child mortality, and up to 74% of maternal deaths around the world.[3] Indonesia is no exception, where the vast majority of maternal, neonatal and under-five deaths that occur each year could be prevented with access to low-cost, basic care, using technologies and approaches that are already broadly available.

Causes of death Indonesia		Evidence based-intervention	Mortality reduction
Maternal			
Hemorrhage	→28%	Comprehensive Obstetric Care	→40%
Infection	→11%	Treatment of infection incl. malaria	→13%
Eclampsia	→24%	Use of magnesium sulfate	→ 7%
Obstructed labor	→ 5%	Skilled attendance	→10%
Neonatal			
Asphyxia	→27%	Skilled attendance	→20-30%
Low birth weight	→29%	Resuscitation	→ 5-20%
		Extra care/warmth	→20-40%
Tetanus	→10%	ANC/physical examination/TT2	→10-20%
Infection / feeding	→15%	Community case management	→10-35%
		Comprehensive Neonatal Care	→10-30%
Child			
Malnutrition	→ 54%	6 essential nutrition interventions	→30-50%
ARI/pneumonia	→ 19%	Community based treatment: IMCI	→30-60%
Diarrhea	→ 19%	ORT / Hand washing with soap	→ 40-50%
Perinatal	→ 18%	Skilled attendance + resuscitation + neonatal care	→ 20-50%
Measles	→ 7%	Immunization	→ 7%

Table 1: Evidence-Based Interventions

THE INMCH MODEL: A PATHWAY TO CARE AND SURVIVAL

A. The Pathway to Care and Survival

HSP commenced in April, 2005 with the aim of scaling up proven, evidence-based interventions to reduce morbidity and mortality among pregnant women, newborns, and children under five. At current rates of mortality, between 10,000 and 18,000 Indonesian families lose a mother each year. Twenty-five children under five die every hour.[4] The vast majority of these deaths are preventable with affordable, evidence-based interventions, but as a result of weaknesses in the health system and poor quality of care, coupled with myriad barriers to utilization and access, women and children

[3] Sines, E., Tinker, A., & Ruben, J., 2006.

[4] The estimates on maternal mortality are based on the 2008 population of 228,248,538 people and the current birth rate of 19.24 births per 1,000 population. The lower estimate is based on an MMR of 228 per 100,000 live births estimated by the2007 IDHS, and the higher estimate assumes an MMR of 420 per 100,000 as estimated by *The Lancet*, 2006.

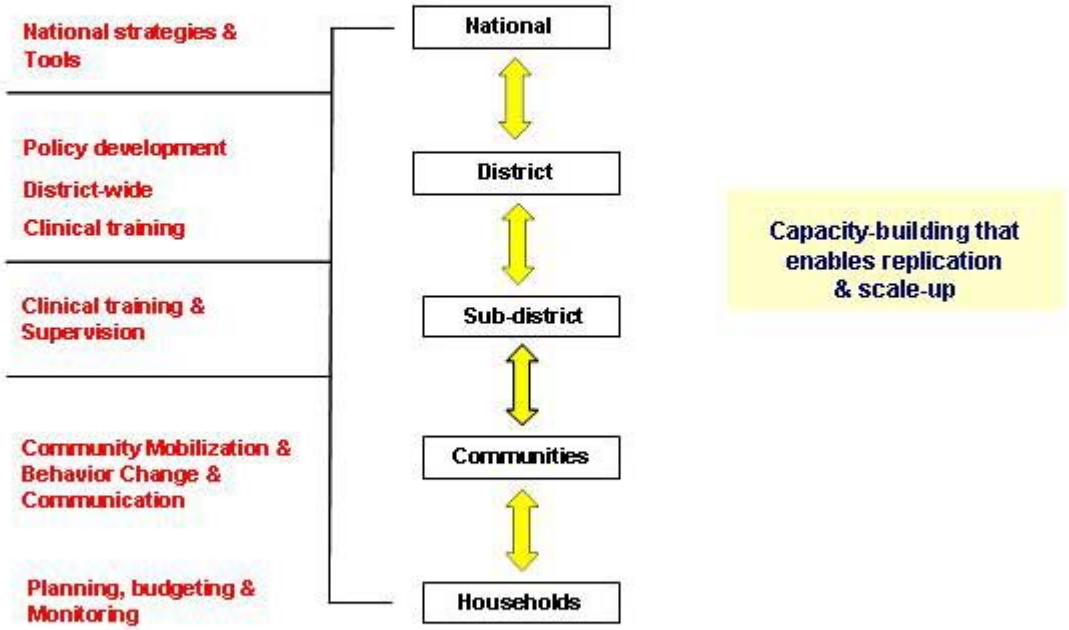
continue to die every day. The integrated approach, known in this report as the Integrated Maternal, Neonatal and Child Health (IMNCH) Model, seeks to break down these barriers to universal coverage of basic life-saving care through a package of interventions that work simultaneously at the level of communities, health providers, and health system managers and policymakers.

The IMNCH Model aims to ensure that:

- Every delivery is attended by a skilled provider;
- Every obstetric and neonatal complication receives timely and adequate management;
- Every woman of reproductive age has access to prevention of unwanted pregnancies and management of abortion complications;
- Every infant and child under five is eligible for comprehensive basic health services;
- Every infant and child under five receives timely and adequate management of illness; and
- Every infant and child under five has optimal growth and development.

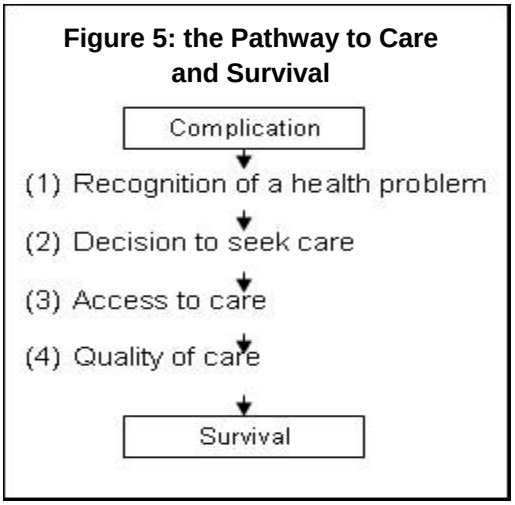
The IMNCH model represents a process of health system change. It is a framework for ensuring a functioning health system that provides a pathway to maternal and neonatal care and survival. Although based on existing elements of the system, work was undertaken to conceptualize the model to provide implementers with a clear methodology for strengthening key functions of the health system.

FIGURE 4: IMNCH MODEL HEALTH SYSTEM APPROACH



The Pathway to Care and Survival forms the core of the IMNCH Model. The Pathway is modeled on the three delays concept, but in this Model is broken down into four steps: (1) recognition of health problems; (2) decision to seek care; (3) access to care; and (4) quality of care. It delineates key steps in care-seeking along a continuum of care from household to facility. Low demand for and delayed use of care, often linked to low acceptability and affordability, are major obstacles to rapidly scaling up effective MNCH services and reducing maternal, newborn and child deaths. Low continuity and poor compliance are also problems in some settings, even where initial usage rates are high.

Figure 5: the Pathway to Care and Survival



At the household and community levels, the first three steps facilitate women and newborns reaching appropriate levels of care, or cause delays in seeking care; these are problem recognition, decision-making to seek care, and logistics to access services. The fourth step addresses the capacity of the health system to provide timely, appropriate, affordable and high quality services with a trained provider at the appropriate level of care.

By building on the Three Delays concept, the Pathway to Care and Survival (Figure 9) provides a conceptual framework for packaging interventions that address both barriers and enabling factors at each stage to ensure that women, babies and children receive appropriate and high-quality care.[5]

As its name suggests, a key tenet of the IMNCH Model is *integration*. It signifies that no single activity, or set of independent vertical interventions, is enough. To effectively and affordably address life-threatening conditions, it is necessary to ensure that several critical systems of the health system are functional and responsive. The essence of the continuum of care concept and the Pathway to Care and Survival is the same; packages of mutually reinforcing interventions are needed to achieve significant population-level reductions in mortality (Campbell & Graham, 2006).

In order to improve MNCH outcomes, diverse groups of actors (e.g., government officials, healthcare administrators and providers, and women and men in the

[5] See Koblinsky et al, 2000.

community) must work together to implement different types of mutually reinforcing interventions. In addition, actions are needed at different levels of the health system to overcome coordination failures that perpetually reduce coverage of services. For instance, the effect of a community-based approach designed to increase utilization of services will not have the desired effect unless the quality of those services improve; bringing women to poor quality services will mean that facility-based mortality rates remain high.

The IMNCH Model provides guidance on combining interventions to address barriers to community demand with efforts to increase the availability and quality of emergency obstetric care, for increased effectiveness (Campbell & Graham, 2006). The documenting of the IMNCH Model builds on the experience of HSP in working with Indonesian partners to develop a sustainable approach for strengthening the Indonesian health sector through four key strategies:

- Working within and through the health system framework and institutions. The IMNCH uses a health systems approach to integrate the tools, skills and procedures with the decentralized district health system, with a special emphasis on data and evidence.
- A strong emphasis on improving human resource capacity. Technical support emphasizes peer-to-peer, active-learning and performance improvement approaches that promote long-term learning and self-sustaining problem-solving.
- Building partnerships. Leveraging the resources of ongoing central and local GOI and externally-supported programs helps to promote sustainability and replication. Implementation of the approach has both drawn on existing partnerships as it has formed new partnerships between the GOI, professional associations, and NGOs both in target districts and at the national level.
- Supporting public-private sector partnerships. HSP worked with partners at the local level to build public-private partnerships, to help sustain program outcomes beyond the life of HSP, including through work to strengthen the financial sustainability and network arrangements of the country's largest network of private sector MNCH service providers through *Bidan Delima*.

By building on existing district resources, programs, and human power, the IMNCH Model supports an efficient, cost-effective, and sustainable approach to reducing maternal, neonatal, and child mortality. The Model promotes replication of approaches by local partners, and emphasizes building local human resource capacity and creating partnerships between local institutions and with the private sector. The set of activities under this framework catalyzes synergy and relationships among: 1) elected and appointed district, provincial, and national public officials; 2) health system managers; 3) service providers; and 4) users of health services within the context of the health system for improving health outcomes.[6]

[6] MPS-CS Strategy Implementation Guidelines, p. 16.

B. Description of the Model

The IMNCH Model supports a district-driven approach that aims to promote sustainable improvements in evidence-based practices within the local health system.[7] The Model is designed to help the district (municipality)[8] governments to more fully implement the national Making Pregnancy Safer and Child Survival Strategy (MPS-CS) by adopting MOH tools and approaches into the district health system, and to do so in ways that build on existing authorities and capacities. The IMNCH Model provides a framework for creating synergy between interventions at different levels above and below the district-level, and helps district governments to connect those interventions through the planning and program implementation cycle of the district government.

The IMNCH Model strengthens key functions of the district health system together through complementary and mutually reinforcing interventions, consolidating tools and approaches that were developed or revised by the MOH – many of them during the period from 2005-2009 with technical assistance from HSP – in order to scale up evidence-based programs under the MPS-CS Strategy. Interventions target three key levels of the district health system to address barriers across the continuum of care, and build the capacity of the health system itself to make sustainable improvements in services. The model is based on the three fundamental processes of ***strengthening health policy and governance***, ***mobilizing and engaging communities***, and ***improving healthcare delivery***.

The Model's focus on ***strengthened policies and governance*** contributes to improving access and quality of evidence-based maternal, neonatal, infant, and under-five services**.** Strengthening health policy and governance reinforces and sustains improvements within the district health system, including through improved planning, financing, health information systems, and management of human and physical resources. A central focus of the model is to help district authorities use MPS-CS evidence-based tools and approaches according to quality standards of care. To establish effective partnerships among programs, sectors, and relevant partners to advocate for maximum resources and improve coordination of MPS-CS actions, the model promotes strengthened health policies and health system governance and leadership, especially at the district level. Key elements of the model contribute to increasing the capacity of district governments to identify needs, plan for, leverage and allocate resources, and implement MNCH programs and services**.** District and sub-district IMNCH Coordination Teams conduct budget and policy advocacy, and strengthen the legal framework for MNCH programs.

Community mobilization and participation are the steps in the IMNCH Model for empowering civil society and improving community providers' capacity to contribute to

[7] The World Health Organization definition of health system is: "all the organizations, institutions, and resources that are devoted to producing health actions (WHO 2007)."

[8] In Indonesia, the level of government or administrative unit targeted by the Model is the district. This is roughly analogous to a municipality in other countries, where health districts may not be synonymous with a governmental administrative/political unit.

improving MNCH health outcomes. These steps strengthen the demand for services, raise awareness, and increase and institutionalize community involvement in health promotion. The model empowers women and families by increasing knowledge and promoting behaviors that support maternal, neonatal, infant, and under five health and utilization of health services. Community mobilization activities aim to remove economic, gender, and other socio-cultural and institutional barriers that prevent low-income women and newborns from accessing care. Through the formation (or strengthening) of groups of community volunteers (known under HSP as Community Health Committees or CHC), the model promotes an institutional mechanism to support MOH-mandated activities to promote birth planning, education about danger signs, prenatal care and IMCI through monthly community-based health service (*posyandu*), active tracking and monitoring of pregnancies and neonates, and community-based financing schemes to help ensure women can access transportation and emergency care. HSP worked with the Indonesian Family Welfare Movement (PKK) not only to strengthen implementation of the health package but to undertake complementary activities aimed at building the capacity of men and women to identify, plan, and finance health actions within their communities, sub-districts and districts. By supporting the formation, or strengthening, and effective functioning of CHCs, the model ensures that the capacity for planning, advocating for, and funding health interventions is institutionalized in village governance structures.

Improved quality of services and capacity of providers, increases women's, newborns' and children's access to primary and hospital level services capable of responding effectively to their needs, especially in emergencies. The Model focuses on improving service delivery to increase the quality of care through clinical training, improved supervision and assessment, and collaboration with the private sector. Given deficiencies in pre-service training in Indonesia, the model identifies how support for clinical training programs can improve the capacity of healthcare center (*puskesmas*) providers and village midwives in providing essential delivery care and postpartum care for mothers and newborns, and in referring appropriately when complications arise. Training, quality-improvement, and certification in CEONC and BEONC at the hospital level ensure available and immediate evidence-based treatment of women and newborns with emergency complications. The model also supports expansion of coverage and improved services through active outreach to the private sector to establish partnerships, leverage funding, and improve quality of care from private sector midwives.

Through the experience of supporting implementation in Indonesia, ***information collection, management, and analysis*** has emerged as a fourth critical process of the IMNCH Model. To provide better information for management and decision-making, the model advocates strategic support to the district health information system by improving community-level monitoring and tracking, and revitalizing the Maternal and Perinatal Audit (MPA) system to better understand the causes of maternal and infant deaths. Emphasis is placed on use of this data for decision-making at each level, from the village up to the district IMNCH Team, both on a routine basis and through evidence-based planning workshops at the *puskesmas* (PTP) and district levels (DTPS). Finally,

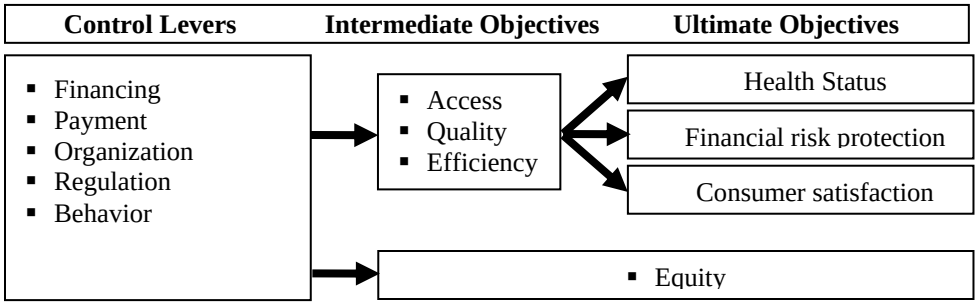
the IMNCH Model strengthens the role of the DHO in promoting evidence-based clinical practice through improved supervision, certification, and accreditation.

While the Model primarily focuses on the public sector, a complementary intervention by HSP provided support to private sector midwives through the Indonesian Midwives Association (IBI). The support to IBI aimed to institutionalize their quality certification program, *Bidan Delima*, and standardize supervision and training tools so that standards were the same for both the private and public sectors.

IMNCH MODEL: A DECENTRALIZED HEALTH SYSTEMS APPROACH

The IMNCH Model describes how key evidence-based tools and approaches can be consolidated into a package of components that strengthen essential functions at each level of the health system. These essential functions are those required to deliver the national MPS-CS strategy at the district level. Each connects to and feeds into other actions within the Model. The aim is to help districts to focus on priority interventions, and build the quality of programming to achieve reductions in maternal and child mortality at three different levels of the health system: improved policy and governance, higher quality services, and strengthened community demand.

Figure 6[9]: Health System Functions and Policy Levers



9

HSP had always been designed for strengthening subnational MNCH service delivery through a packaged approach. After the award of the agreement, it was determined to extend coverage, including for tsunami-affected Nanggroe Aceh Darussalam, to 31 districts across six provinces. Given this scope, the ability to test the package as a Model was not possible. A health system strengthening focus was maintained however, and districts undertook needs assessments to determine the priorities for assistance; those that would have the greatest impact on reducing maternal, neonatal, and child mortality and morbidity. All assistance and support provided by HSP is predicated on the premise that responsibility for the overall system and the delivery of services rests with the GOI and that all HSP support is provided as a means of strengthening the national system.

[9] From "An Integrated Approach for MNCH Improvement Through District Health Systems: From Indonesia"

A recommendation of a 2008 program evaluation was that HSP should document the overall Integrated MNCH Model. This was also a request of the MOH, as they also saw that many aspects determining service delivery at the district level were beyond their purview. It was agreed that for the 2009-2010 project extension, coverage of the program be reduced to two districts; *Kabupaten* Malang and *Kabupaten* Pasuruan, both in East Java, were chosen. The purpose of this was to allow HSP to support the two districts in implementing a complete package of MNCH interventions – in support of the MPS-CS Strategy, but also taking advantage of opportunities presented by other sectoral programs – and to document this process in order to provide advice to the MOH, to other districts, and to USAID to guide future programming. The IMNCH Model therefore describes not only the package of assistance supported by HSP, but also a Model that districts themselves can draw on in determining better integration of the existing elements of the local health and district government systems.

The WHO defines the health system as including the "organizations, institutions, and resources that are devoted to producing health actions". In order to effectively address all the key functions, the IMNCH Model strengthens:

1. Policies, governance, planning and monitoring through enhanced and more accountable planning and financing, and participatory evidence-based decision making;
2. Services through improvements to the management of human and physical resources; and
3. Civil society's engagement in policy formulation, planning, delivery, and oversight of healthcare.

The actions of the Model (see diagram on page 16) contribute to strengthening critical functions at different levels of the health system. The diagram demonstrates how key actors and institutions are engaged in the strengthening health system functions at different levels of government (national, provincial, district, and village). Both public sector and private sector organizations also play critical roles in implementing activities that improve the engagement of civil society in planning for and oversight of health services; the quality of health services, and the allocation and management of information and human and financial resources necessary to achieve an timely and effective response of the health system to complications that contribute to maternal and neonatal mortality. It also illustrates the sequence of planning and implementation according the Indonesian district planning cycle of the IMNCH Model.

This cycle of activities, documented by the IMNCH Model, is therefore largely driven by the national planning cycle; this would be the same for implementation of such a program in any national context. Other activities are embedded in the system but are not essential to this cycle. While HSP attempted to determine a preferential order, real-time implementation may not always allow for this. Support to these other elements is flexible enough to accommodate implementation delays and also to take advantage of any political opportunities that may determine the need for promoting or delaying particular activities.

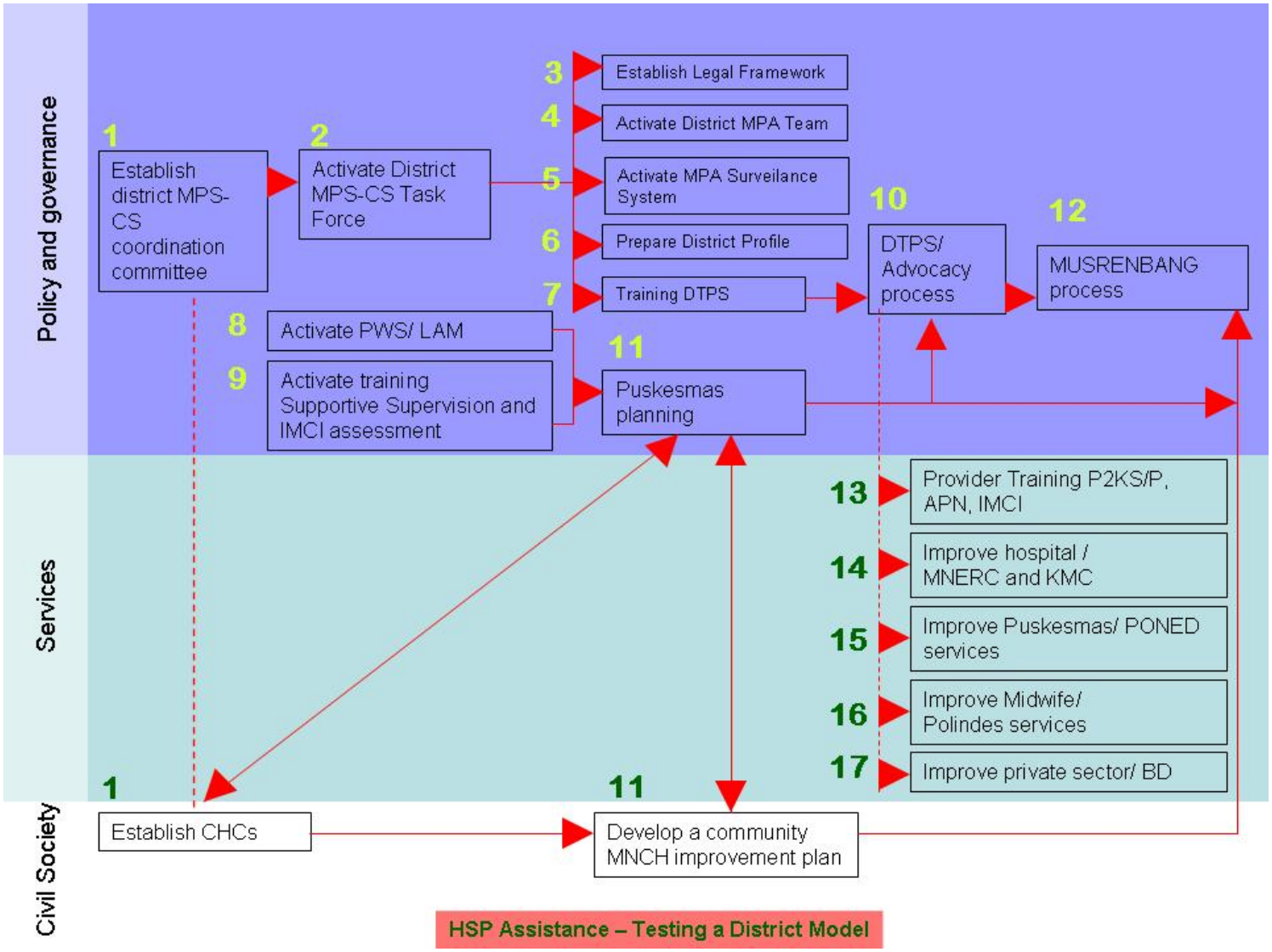


Figure 7: IMNCH Implementation Process in Indonesia

A. Planning and Monitoring

One of the greatest challenges in reducing maternal, neonatal, and child mortality is getting a level of political commitment that allocates sufficient resources both over time and in line with a realistic evidence-based profile of need and proven responses. Advocacy efforts are critical to gaining the political backing of policy makers, but the marker of real commitment is investment, targeted to priority interventions in human resource development, infrastructure, and the operational systems necessary to save women's, babies' and children's lives. Planning based on timely and verifiable information is essential to directing the resources equitably and efficiently to the highest impact investments.

Taking an integrated approach to MNCH planning involves interventions at the village, sub-district, and district levels, involving both government planners and civil society. Activities at each level are different but interconnected, often involving the same stakeholders.[10] Since 2006, HSP has supported the development or revision of tools and activities for building the capacity of district governments and health providers to plan and implement evidence-based interventions for reducing maternal and neonatal mortality. District Team Problem Solving (DTPS) and *puskesmas* planning (PTP) provide the concrete tools for health planners; while advocacy activities target the policy makers who have final say on district resource allocation. For healthcare providers, tools such as Supportive Supervision, Integrated Management of Childhood Illness, and Behavior Change Communications (BCC) provide a framework for planning service provision, based on evidence. In villages, work with the Community Health Committees on conducting community needs assessments and preparing funding proposals for both GOI sources as well as possible private sector supporters provides the basis for long-term sustainability. As well as resulting in plans, the planning activities have a number of other positive results: they have helped to raise awareness of MNCH issues and evidence-based interventions among health planners, decision makers and the community; they have increased the availability of and use of data in the planning process; and they have promoted the role of civil society in communicating local needs and holding providers and policymakers accountable for improving services.

HSP support had initially been focused on the health technical planning stream, but over time experience showed that final district resource allocations were being influenced by the results of the national bottom-up planning process known as the Development Planning Forum (*Musyawarah Perencanaan Pembangunan* or *musrenbang). Musrenbang* applies to all sectors, and has tended to result in more 'tangible' projects, such as small infrastructure, rather than support for social or welfare activities. As well as its importance at the District level, the process was also, in many cases, driving decision-making for allocations at the village level. In order to increase available MNCH funding at local levels, HSP began supporting CHCs to leverage this process by undertaking an evidence-based needs assessment and plan for presentation to the village-level *musrenbang.*

[10] From *the Proposed Process for the Case Study and Process Evaluation of Integrated MNCH Planning System in Two Pilot Districts (Kabupaten Malang and Kabupaten Pasuruan).*

1. District Planning and Budgeting

The national planning cycle determines and regulates planning and budgeting activities to be undertaken at village, sub-district and district level and across all sectors. HSP provided technical assistance to this process for improved MNCH outcomes by supporting greater use of the MOH tools at each level. Support was provided not only to the health (technical) planning stream, but also to the *musrenbang* stream, both of which converge in the Forum SKPD, where health-related priorities from the *musrenbang* are integrated with DHO planning. A key aim of HSP support was to strengthen the capacity of key players to advocate MNCH issues to the higher level, especially in budget planning, and to promote coordination between *musrenbang* and DHO planning.

One of the central elements of the district health technical planning is the District Team Problem Solving (DTPS) process. DTPS is a structured planning process that helps the DHO and other key district government stakeholders, such as *Bappeda* (District Planning Agency) analyze data on MNCH problems, prioritize appropriate interventions and develop and submit an evidence-based plan and budget for improving services that can address those problems. By structuring the planning process and by integrating levels of intervention, DTPS increases coordination of planning across different sections of the DHO. DTPS results can be used to develop DHO budget requests and work plans, in addition to informing advocacy efforts and *musrenbang* activities.

District Team Problem Solving was introduced to Indonesia by the WHO and UNICEF, who promoted it as an approach to improving evidence-based planning for MNCH. However its use was largely limited to the development of project activity proposals. With HSP support, the Ministry of Health adapted the tool for use as part of the mainstream District health planning process. This saw the tools aligned with the national planning cycle.

To initiate the DTPS, a multi-sector group of stakeholders from different government agencies and civil society groups come together to form a District MNCH Committee. Mandated under the National MPS-CS Policy, the District Committee coordinates planning, budgeting, and collection and analysis health information across different governmental entities.[11] The DTPS Guidelines provide the roadmap for the planning process which begins with an orientation to the methodology.[12] After going through the orientation, a smaller group, led by the District Health Office, becomes the DTPS Planning Team. They go through five day workshop on the DTPS process.[13]
Once trained, the first task of the DTPS Team is to conduct a *situational analysis*. The planning team collects health data and information to assess the health situation of women of reproductive age and children younger than five years of age. Data comes from different sources, such as health facility records, program indicators, ad hoc

[11] The process is guided by the MOH's *Book1: Guidelines to the Planning Process developed with HSP assistance*.
[12] *Book 2* is a facilitator guide for the multisectoral orientation meeting.
[13] The training is captured in MOH *Book 3: Facilitators Guide to the Planning Process*.

surveys, or reviews. The planning team reviews quantitative and qualitative data from sectors relevant to MNCH programming.

In order to focus on the most critical problems affecting MNCH, the team uses the information collected during the situational analysis to *prioritize problems* in light of available resources and the most cost-effective use of those resources. The entire team participates in the prioritization according to criteria they develop for ranking the relative severity and feasibility of addressing problems. Prioritization of interventions and activities considers the following dimensions:

- *Consistency*: compliance of an intervention/activity with the national strategies and the district work plan;
- *Supporting Evidence*: the extent to which evidence on best practices and standards of quality of care support the types of effectiveness of alternative solutions;
- *Acceptance:* how acceptable the activities are likely to be for stakeholders, especially for women, their families, and communities; and
- *Feasibility*: how easily an intervention can be implemented under existing local conditions of facilities, human resources, and infrastructure, or how likely it might be to improve those conditions.

Once the team has identified the problems, they conduct a secondary level of analysis to identify the *main causes* of the problems using methodologies such as the problem tree or fishbone analyses. This information provides the basis for identifying potential interventions and activities to address the prioritized problems and their causes.

The situational and problem analyses help to determine whether proposed programs are likely to achieve results. They also reconsider the relative feasibility of alternative approaches according to the availability of resources, contextual factors (e.g. demographic and health profiles, cultural acceptability, and geography), and current policies and regulations. Health system factors considered in the analysis include:

- Drug and commodity security;
- Morbidity and mortality in target groups;
- Coverage of MNCH services;
- Supporting and complicating factors for the delivery of MNCH services; and
- Availability of MNCH program “tracer drugs”.

The strategic planning phase of the DTPS entails identifying alternative solutions based on the identified causes. It also includes an analysis of potential effects of the proposed interventions on different stakeholders, as well as considerations of the prospects for receiving political and financial support for the activities. Finally, the team draws on this analysis to develop a strategic plan with objectives, activities, indicators, and the number and type of human, financial, and maternal resources needed to implement the plan. They also develop an implementation schedule.

DTPS also is informed by planning processes that take place at the sub-district and community levels. The first of these is the planning that takes place at *puskesmas;* the second is the village *musrenbang*.

The DTPS-MNCH Planning and Budgeting Tools*

Book 1: Planning Process Guidelines – Guidance for MNCH planners to develop a needs-oriented and evidence-based plan for maternal, neonatal and child health and nutrition.

B**ook 2:** Facilitator's Guide for the Multi-stakeholder Orientation – A step-by-step manual for orienting planners, legislators and advocates to the DTPS-MNCH planning and advocacy process.

Book 3: Facilitator's Guide to the Planning Process – A manual to support facilitators who are leading the MNCH planning and budgeting process.

Book 4: Reference Book for Budget and Policy Advocacy – A collection of handouts on policy, building alliances and other strategies for MNCH advocates.

Book 5: Facilitator's Guide to Budget and Policy Advocacy – A manual to support facilitators who are training MNCH advocates.

* With HSP support, the MOH distributed more than 3,500 sets of the DTPS-MNCH series.

2. Sub-District Planning

The main planning vehicle targeted by the IMNCH Model at the sub-district level is the health center planning. Health centers, *pusat kesehatan masyarakat* or *puskesmas,* provide health education and basic clinical care at the sub-district level and supervise delivery of the same at health posts (*polindes*) staffed by midwives in villages. As they are the DHO representatives closest to primary healthcare, *puskesmas* staff play an important role in the health planning. HSP provided support to *puskesmas* level planning (known by the Indonesian acronym, PTP) through technical assistance for the development of guidelines[14] and training to strengthen the planning capacity of *puskesmas* staff and managers. These interventions strengthened the existing annual planning process that most *puskesmas* already followed, by incorporating elements of the DTPS – particularly related to use of data and evidence.

Similar to the DTPS, sub-district stakeholders form a MNCH planning team; they also collect and analyze health information on the population in the subdistrict and prioritize activities according to identified priorities, causes, and evidence-based solutions. The fortified PTP process produces a *puskesmas* annual workplan and budget request that is more grounded in the actual health situation faced by local populations and better addresses local problems with prioritized evidence-based approaches.

The PTP also incorporates the results of the *musrenbang* at the subdistrict level to provide direct input to the district DPTS process. Even though the DTPS and

[14] The methodology for *Puskesmas* Planning is found in MOH *Planning Guide for Puskesmas*

musrenbang processes eventually come together, there is always the danger that health priorities might be dropped in favor of other sectoral priorities as competing issues from the various sectors and sub-districts are negotiated at the district level. The *puskesmas* plans can capture those proposals as they come up from the villages and in turn can also work with village midwives to ensure that health priorities are put forward by the Community Health Committees through the village *musrenbang* (see below). These are sent to the DHO and subsequently included in the plans and budgets submitted by the DHO to local governments to inform district-wide plans and budgets. After budgets are set and approved by the district executive (*Bupati*) and legislative (DPRD) governing bodies, the information is sent by the DHO back to the *puskesmas* for them to adjust their plans to reflect real funding levels and district-wide priorities. Occasionally, *puskesmas* have access to other funds that come directly to them outside of the district budgeting process and these are also factored into their revised plans.

3. Village Planning – *Musrenbang Desa*

Musrenbang is the central component of the national "bottom-up" planning system, consisting of consultative forums held at the village, sub-district, and district level for the purposes of soliciting public input for annual district planning. HSP activities support the prioritization of MNCH within the *musrenbang* process, complementing other activities (such as DTPS and advocacy) that target the district government planning process directly. While *musrenbang* is intended to provide input for district planning, the process engages decision-makers at the village and sub-district levels, creating the possibility of influencing the allocation of other fund sources outside of DHO control (e.g. village funds or special allocations such as the National Community Empowerment Program or PNPM). In addition, *musrenbang* meetings at each level provide opportunities for communication and cooperation between civil society, health providers, and the DHO, which can increase public accountability for providing MNCH services.

With these outcomes in mind, HSP concentrated support for *musrenbang* planning at the village level. Through the *musrenbang desa*, villages determine their priorities and budget plan, including priorities to be passed up to the sub-district level. The element of the integrated model supported by HSP that contributes to ensuring the *musrenbang* process considers – and more importantly, selects proposals for MNCH investments – is an active Community Health Committee (CHC) in each village. HSP supported the establishment or strengthening of CHCs to perform key health activities. Training was provided for both CHC representatives and village midwives to develop and advocate MNCH priorities during the *musrenbang*.

Village participants in the *musrenbang* discuss the health plan put forward by the CHC and analyze village-level health information, presented by the village midwife or a representative of the CHC. In preparation, the village midwife (*bidan di desa*) and the health volunteers (*kader*) have synthesized health information collected over the year at the monthly health fair (*posyandu*) and the health post (*polindes*). These data are now drawn from the LAMAT village surveillance system (see below). The CHC then facilitate a pre-*musrenbang* participatory analysis of the data during which participants identify

problems, and develop a plan of action to address them. It is this resulting plan that is presented at the *musrenbang* meeting for funding. Some of the activities receive funding from budgets available for immediate allocation by the village administration. Proposals deemed worthy that cannot be accommodated in the village budget are brought to the sub-district *musrenbang*, where villages can come together and agree on priorities to be passed up to the district level.

The village midwife is both a member of the CHC and also the representative of the *puskesmas.* As such, she is the person who facilitates the interface between village-level and sub-district (at the *puskesmas)* planning. *Bidan di desa* participate in both village and *puskesmas* planning, where village proposals are also reviewed and elements may be considered for support.

Prioritizing MNCH from the Bottom-Up through Musrenbang Planning

According to a 2010 HSP case study of the district planning process – which included observations of actual *musrenbang* as well as interviews with village, sub-district, and district officials – was broad participation of the health sector in *musrenbang* at the community level, and signs of better integration of *musrenbang* and health sector planning processes, there were noticeable results from Malang and Pasuruan Village Health Committees' presentations proposals for improving MNCH through the *Musrenbang*. Whereas in previous years MNCH-related proposals reportedly were not broadly discussed, in 2010 they were discussed in the vast majority of *musrenbang* meetings observed. At the village level, most villages observed accepted at least one MNCH proposal for inclusion in *musrenbang* requests to the next level (83%) or for funding from local sources (47%). As shown in the Table 2 below, many of the activities proposed were in line with MOH priorities for community-based MNCH programming, such as operation of the *posyandu*, community training or education, and birth preparedness activities. In Pasuruan, where *musrenbang* was observed up to the district level, MNCH was also broadly discussed as a district priority, which one DHO official said would likely lead to stronger political support for increased funding in 2011 (*Ibid: p17*).

Table 2: Percent villages/sub-districts that discussed specific MNCH Proposals in *Musrenbang* (2010), by type of activity type

	Malang		Pasuruan		Overall	
	Villages (n= 33)	Sub-districts (n=19)	Villages (n= 38)	Sub-districts (n=7)	Villages (n= 71)	Sub-districts (n=26)
Supplemental feeding	64%	68%	63%	71%	63%	69%
Community training / education	67%	79%	47%	43%	56%	69%
Other health activities (non-MNCH)	21%	53%	42%	43%	32%	50%
Operational funds for *posyandu* (i.e. stipends or transport funds for *kaders*)	36%	32%	26%	43%	31%	35%
Infrastructure, drugs, or equipment (including maintenance)	39%	74%	21%	86%	30%	77%
Other birth planning / preparedness activities (e.g., village ambulance system, identification of blood donors)	21%	37%	24%	0%	23%	27%
Establish a community birth fund	6%	11%	32%	14%	20%	12%
Other MNCH-related activities	18%	21%	16%	43%	17%	27%
Monitoring and/or tracking of pregnant women & newborns	15%	26%	13%	14%	14%	23%
Health worker training	3%	37%	3%	14%	3%	31%

B. Policy, Leadership, and Governance

In many developing country settings, development challenges are less due to a lack of appropriate policies and more to a lack of political will or leadership. Under decentralization in Indonesia, one manifestation of increased autonomy at local levels has been a drop in compliance with national policies and guidelines.

Building political commitment is one of the challenges of the IMNCH Model. In order to do so, strategies for advocacy and developing local legal frameworks were developed. This approach proved successful in that political, civil and administrative leaders claimed ownership of a locally-developed push for improved MNCH rather than feeling that they were simply implementing national policy.

For HSP, support to this approach also meant facilitating local partners to determine how nationally-approved guidelines or policies could be useful and were adaptable for local needs. The national MPS-CS strategy dictates that each district should have district and sub-district committees for improving MNCH, yet these were rarely

operational. These MPS-CS or MNCH committees are a useful vehicle for involving the *Bupati* and other cross-sectoral partners in health decision-making and also help to coordinate between the DHO and hospital, which are run as separate administrative departments at provincial and district level in Indonesia. With HSP support, these committees became to be seen as a means for overseeing the implementation of local level laws for MNCH; the *perda, perbup* and *perdes*. By demonstrating how these committees could serve a local need, political commitment to establish and sustain the groups was forthcoming.

Strengthening district-level legal frameworks in support of the MPS-CS policy was another avenue through which HSP saw an opportunity to leverage ongoing political commitment and institutionalize health system improvements made with HSP support. HSP supported district governments to review and clarify their own responsibilities for improving MNCH programs and services through the establishment of district laws and regulations, and the issuance of formal decision letters regarding program implementation. Since decentralization, some districts had interpreted their autonomy to mean an absence of responsibility to national technical ministries and implementation of their policies. Key goals, therefore, of issuing district-level regulations related to MNCH included: incorporating a focus on improving MNCH services into district law in order to improve the sustainability of programs currently underway and to provide a rationale for allocating more resources in the future; providing a legal mandate for the DHO and other key stakeholders to implement and strengthen a comprehensive MNCH improvement program; improving transparency and advocacy by clarifying responsibilities of district government; and clarifying the roles and responsibilities of key stakeholders with respect to MNCH programs.

1. Advocacy

Advocacy is the cog that turns the wheels of the planning, governance, community mobilization, monitoring, and improvement of health services components of the IMNCH Model. Advocacy moves activities from planning and budgeting to action and accountability. Advocacy activities are aimed at building the capacity of civil society to lobby policymakers to make the necessary financial and political commitments. Advocacy aims to increase funding and support for improved MNCH services. In Indonesia this process entailed engaging civil society to lobby for the passage of local statutes to implement national MNCH health initiatives and policies. Passage of MNCH statutes in turn strengthened the capacity of advocates to lobby for allocation of funds through the district planning process. With the legitimacy provided by the statutes, advocates were able to work in team to ensure that the DTPS funding requests are approved through the political process, in addition to enabling civil society actors to hold policymakers accountable for commitments to improve MNCH over successive planning cycles.

HSP supported advocacy teams worked with District Health Offices, NGOs, parliamentarians and others to create alliances around maternal and child health (MNCH) issues at the district level, with the eventual outcome of passing local MNCH

laws (*peraturan daerah* or *perda*). These local regulations provide guidelines for policy-makers to prioritize budgeting for health and to implement health programs, including for maternal and child health. In Indonesia, HSP advocacy teams have helped to pass thirteen MNCH-related district ordinances.

To foster and strengthen local advocacy initiatives, HSP provided seed funding and technical assistance to form multi-stakeholder district MNCH Advocacy teams that were encouraged to play an active role in the implementation of the District MNCH program. In particular, HSP worked with District Health Offices, NGOs, parliamentarians and others to create alliances around MNCH issues at the district level. The first step to forming MNCH Advocacy teams was to conduct a mapping of key stakeholders in local government and civil society, followed by the formation of a multi-stakeholder team. To strengthen the team and jump-start activities, HSP supported 3-day organizing workshops that helped teams to build consensus around the urgency of MNCH challenges and develop messages and strategies for advocacy, and culminated with a real advocacy presentation before the DPRD or the District Head, known as the *Bupati*. Following the workshop, the teams formulated action plans and implemented advocacy campaigns which were tailored to each district according to local commitments. Examples of local initiatives included media campaigns and discussion of MNCH issues on radio and television shows, the development of advocacy videos and press kits, and additional meetings with policymakers. HSP provided seed funding and logistical support for team-building activities.

In addition to increased funding and new legislation, HSP supported advocacy as an intervention to promote healthy behaviors and clinical practices, such as through training providers and midwives across to advocate on behalf of immediate breastfeeding. Through a "celebrity" advocate, HSP helped reach over 23,000 stakeholders with key messages about the potentially life-saving value of initiating immediate and exclusive breastfeeding within an hour of birth and, for the first six months of the child's life.

HSP also supported advocacy at the village level, by including advocacy as part of the training for CHCs, which they used to push for the adoption of MNCH investments through the *musrenbang*. Many villages also passed village level ordinances to mandate planning and budgeting of community resources for MNCH.

Table 3: Number of People Trained in Advocacy 2005-2010

Master Trainers (for the MOH and national NGOs)	19
National Trainers	20
National Trainers (NGOs partners)	19
Advocacy Skills	613
Legal Drafting	151
DPRD Orientation	664
Leadership	59
Attended Workshop on the Early Initiation of Breastfeeding and The International Code of Marketing of Breastmilk Substitutes	23,374

2. Legal Framework[15]

2.1 District level MNCH Statutes: Under Indonesia's decentralized health system, local-level governments have the authority to develop and use legal frameworks across a wide spectrum of social services, including health, that are consistent with national-level laws and other regulatory measures, and govern both the generation of local resources and use of funds for various publicly delivered services. At the district level, *perda* (*peraturan daerah*), or regional regulations, are the primary means by which district legislative bodies (DPRD) can operationalize and influence both the supply and demand of services (World Bank, 2008). *Perda* can also be used to govern lower-level decentralized decision making, for example, by mandating a certain percentage (e.g., 10%) of the current annual budget to be allocated to sub-districts and villages for development purposes (Ahmad & Weiser, 2006).

District-level *perda*, mayoral decrees (*peraturan bupati* or *perbup*) and official instructions, (*Surat Keputusan* or SK) can be developed across a wide array of functions, including regulations related to annual budgets, local taxes and fees, allocation of resources for decentralized public services (e.g., health and education) and management of natural resources (Decentralization Support Facility, 2007). These local regulations provide guidelines for policy-makers to prioritize budgeting for health and to implement health programs, including for maternal and child health.

HSP had initially provided support focused on passing *perda.* Different districts took different approaches depending on political imperatives; however in total thirteen district laws were passed under the first phase of the program. Under the extension phase, the districts of Malang and Pasuruan indicated that they considered the formulation of a *Peraturan Bupati*, or *perbup*, an important step in operationalizing their *perda*. Under the *perda*, some legal articles were not explicit and required further explanation in terms of how the law could become action. While *perda* are issued by DPRD (regional parliament), *perbup* are issued by authorization of the *Bupati*, or district head. HSP support provided specialist advice in legal drafting and advocacy for development of the additional legal instruments, with the aim of translating legal and policy directives into technical realities.

[15] This section taken from "HSP Case Study: Institutionalizing MNCH Programming through Local Legal Frameworks".

Leveraging Local Legal Frameworks for MNCH*

In the context of Indonesia's decentralized health system, the development of local laws and regulations – including *perda* (*Peraturan Daerah*, or regional regulations) at the district-level – can be a useful tool for spurring local action to help meet national MNCH goals in Indonesia. This was among the main conclusions of a 2010 case study of HSP-supported efforts to pass MNCH regulations in four districts (Malang, Pasuruan, Cianjur, and Serang) across three provinces (Banten, East Java and West Java), which surveyed some 125 heath sector stakeholders and government decision makers at the village, sub-district, and district levels. In the three districts that passed such *perda* – two of which were specific to MNCH, and one focused on the health system broadly with MNCH as a component – they were found to provide an effective means to articulate local needs and priorities related to MNCH programming. *Perda* were also broadly perceived by stakeholders as useful for increasing commitment and support from other government agencies, clarifying roles and responsibilities, providing a basis for monitoring MNCH programs, and serving as a basis for advocacy.

In Malang and Pasuruan, passage of the MNCH *perda* was followed by the development of additional regulations - including *perbup* and village regulations (*Peraturan Desa,* or "*perdes*") – that played an important role in operationalizing the *perda*. These additional regulations helped to clarify roles and responsibilities to a greater degree than the *perda*, as well as provide operational instructions to implementers and partners. The study also indicated that p*erda* and *perbup* were actively used for decision-making regarding MNCH programs, including as justification for funding increases, changes to activities or strategies, and changes in personnel. *Perdes* helped to give formal recognition and an institutional foundation within the village for community-based MNCH activities.

The study found that the approach of developing MNCH regulations is replicable and adaptable to needs and political realities in different settings, and that it can be valuable as part of a broader, integrated district approach to reducing maternal and neonatal mortality. At the same time however, the success of the approach depends on the strength of local support and advocacy. Furthermore, while passing a legislative law was seen as a significant step, a law alone is not enough - successful implementation is likely to require ongoing external reinforcement or technical assistance, such as from higher levels of the health system. Recommendations for future scale-up of the approach include building this capacity amongst existing health authorities.

*From: *Institutionalizing MNCH Programming through Local Legal Frameworks*

2.2 Local Ordinances Supporting Implementation of District Statutes: Village governments are also able to establish regulatory frameworks to support the funding and delivery of basic services including health. Recent changes in Indonesia's governance policies strengthen the authority of the legislative branch of village government (the BPD) vis-à-vis village executives (heads). Villages have the legal authority to regulate and oversee community interests[16], including passage of village regulations (*perdes* or *peraturan desa*).

With HSP support, community facilitators were also instrumental in convincing village councils to pass local ordinances in support of MNCH. The *perdes* seek to leverage political commitment, for example, by codifying a commitment to guarantee funding or even to earmark portions of the village budget (APBDes) for village-level MNCH activities. *Perdes* also institutionalize the CHC by allocating annual funds for MNCH

[16] Ministry of Home Affairs regulation 29/2006 on the Technique for Drafting *Perdes*, Village Head Regulations, and Village Head Decrees

activities, and formally mandating the inclusion of the Committee in all village planning processes, including the *musrenbang*.

Impact of Village *Perdes* (MNCH Ordinances) on MNCH Activities

There were several ways in which respondents felt that *perdes* would impact the delivery of MNCH services. As indicated in Table 4, the majority of respondents felt that *perdes* would require both the CHC and village government to undertake activities not previously undertaken. Interestingly, stakeholders appeared to perceive *perdes'* impact on their own activities as less influential than on others' activities. For instance, fewer health sector (compared to village government) respondents felt that *perdes* would require *posyandu* and village midwives to conduct activities not done previously, whereas the converse was true for requirements on village government activities. In addition, all HSP-supported villages had received training and facilitation in *perdes* development as a component of the integrated package of assistance for village-level MNCH activities, which may have contributed to the perceived changes reported by respondents. *

Table 4: *Perdes* requirements on stakeholder activities

Stakeholder	Health* (n=15)	Village Gov't (n=16)	Overall (n=48)
CHC	50%	56%	52%
Posyandu	38%	53%	43%
Village midwife	31%	50%	38%
Village government	75%	63%	71%

* Health: village midwife/Kader respondents

Table 5: Use of *perdes* to advocate for/improve MNCH-related actions

Use	Malang (n=15)	Pasuruan (n=12)	Overall (n=27)
Frequency of CHC meeting	100%	100%	100%
Support from the village government for health activities	100%	100%	100%
Posyandu activities	100%	100%	100%
CHC / midwife participation in *musrenbang*	100%	100%	100%
Funding for health activities from APBDes	100%	75%	88%
The type of village health activities conducted	93%	100%	96%
Cooperation between midwife & TBA	93%	92%	93%
Health information system / active surveillance activities	93%	92%	92%
Implementation of community-based MNCH programs†	93%	100%	96%
Health insurance for the poor	100%	92%	96%

†† Including *Desa Siaga* and P4K(Birth Planning & Complication Readiness Program).

*From: *Institutionalizing MNCH Programming through Local Legal Framework*

C. Engagement of Civil Society

1. Community Mobilization and Behavior Change and Communication

Most maternal deaths are caused by direct causes such as hemorrhage, infection, eclampsia, prolonged labor, and abortion complications. Increasing evidence demonstrates that maternal deaths are closely linked to the interplay of underlying

factors such as poverty, youth, lack of education, gender inequality, and rural residence, all of which contribute to the three delays: the first delay in deciding to seek care; the second delay in reaching care; and the third delay in obtaining care once arriving at the health facility. The IMNCH Model encourages an approach that addresses these delays with four strategies:

1. Empower women, families and the community;
2. Improve the quality and access to maternal and child health services;
3. Collaborate with other programs, sectors, and community including the private sector; and
4. Improve MNCH surveillance, monitoring and evaluation and financing.

Community participation is fundamental to implementing all four strategies to prevent the three delays. To support effective community mobilization, HSP worked primarily within the health system, building the capacity of district and sub-district level partners (including from the *puskesmas)* to facilitate community-based responses to key health concerns. In early stages of the program, HSP district-level staff worked with village counterparts to identify key community leaders, who were then provided with training and support. Key tasks and skills addressed with HSP assistance included community involvement, participatory community health assessments, and planning. Once a village formed a Community Health Committee (CHC), HSP provided support to implement modules in the areas of birth preparedness and complication readiness, hand washing with soap, and early and exclusive breastfeeding. The extension phase of the program supported the replication and scale-up of these activities through a partnership with the Family Empowerment and Welfare Movement (*Pemberdayaan dan Kesejateraan Keluarga* or PKK), the largest mass movement in Indonesia.

1.1 Birth Preparedness The IMNCH Model includes a number of efforts to **empower and improve** community **access to quality services**. The primary goals are to ensure all pregnant women deliver with a skilled midwife, recognize and seek care in the event of an emergency during delivery, immediately breastfeed their baby, and seek post-partum care. Communities organize to provide emergency transport, identify and facilitate blood donations, and develop safety net funds to pay for care or transportation in the event of maternal or neonatal emergencies.

HSP support for these activities was part of a package of support to the Ministry of Health's P4K program of Birth Preparedness and Complication Readiness. The program promotes the use of placing a visible sticker on the house of every pregnant women with information on the woman's: (1) name; (2) due date; (3) intended place for delivery (e.g. home, health post, health center, hospital); and (4) blood donor. HSP supported facilitation for CHCs to identify local solutions to some of the major barriers to women accessing care, such as lack of money for transportation and healthcare fees. With HSP support, CHC members were educated on the national social health insurance scheme in order that they use this knowledge to assist eligible villagers to enroll. Most CHC also set aside community resources to help cover costs for poor women in their villages. To support both the cost of implementing the activities and

providing funds for poor families, some CHCs developed their own community-based income generation schemes.

HSP supported the MOH to develop Guidelines on Birth Preparedness and Complication Readiness with Sticker, which were later formally issued by the Ministry (MOH 2009), as a reference for P4K implementation. These guidelines are central to the effort to empower and mobilize the community to accelerate the reduction of MMR.

2. Revitalization of MNCH Monthly Fairs (*posyandu*) and Community Volunteer Training

The implementation of village-level activities relied on a strategy of reinforcing the existing role of community volunteers through established chapters of the PKK *Pokja IV* at the village, sub-district, and district level. *Posyandu* volunteers and CHC members are often already members of the PKK *Pokja IV* rather than encourage the establishment of new groups, HSP promoted linking CHC activities to the PKK to provide a platform for institutionalization. HSP support was adaptable to existing village groups where present; the support simply sought to ensure that group was conducting the key activities. In order to ensure sustainability, HSP established a partnership with the PKK in each district to serve as the primary implementer of for replication and scale-up of community programs in each district. The PKK has a mandate for mobilizing *kader* for a range of welfare-related activities including health; Working Group IV (*Pokja IV)* is the responsible sub-committee at each level of government, including the village. HSP staff worked with the PKK to identify candidates at the sub-district level to become community facilitators. HSP supported training for these facilitators and then supported and mentored them to provide training to the village level.

The *posyandu* system is one of the primary initiatives of the GOI for extending basic maternal and child health services down to the village level throughout the country. A *posyandu* is a monthly integrated MNCH fair at the community-level staffed by community volunteers known as *kader*, who are often from the local chapter of the PKK *Pokja* IV*. Posyandu* provide a platform for integrating different vertical health programs at the community level, including family planning, nutrition, maternal and child health, immunization, prevention of diarrhea, registration, weighing of infants and children under five, filling out of the health card, community education, and services from a skilled provider – usually as outreach from the *puskesmas*.

To strengthen the quality of these services, HSP supported refresher training of trainers in each district for PKK Community Facilitators, Coordinating Midwives from the *puskesmas*, and *kader posyandu* from selected villages. The refresher trainings reinforced the importance of the package of health activities, and especially the P4K program. The trainings emphasized the role of *kader* in identifying pregnant women and newborns, as well as following-up to ensure they receive care, and participants developed follow-up plans to cascade the trainings to all target villages. HSP also assisted the MOH to reprint MCH Books (health cards) for mothers and children that were initially developed with support from JICA. These cards contain information about

essential care during pregnancy, childbirth, and for children under five, as well as a form used by local health workers and by the mother to record information from women's and children's visits to the health services.

The training of trainers also covered the needs assessment and planning process related to the *musrenbang* that is described under the planning and legal framework sections above. These activities serve to institutionalize the health activities and provide routine funding for their implementation from locally available sources.

Each training session also emphasized routine use of data for activity implementation and for proposal development. Also important as part of P4K implementation, was the role of *kader* in undertaking active surveillance. These activities are described under the section on LAMAT.

3. Behavior Change and Communication and Building Commitment to Healthy Practices through Advocacy

Tools for Community Mobilization and Behavior Change and Communication

1. Training manual for District Health Office staff to improve their capacity in Behavior Change Communication
2. Guidelines on inter-personal communication and counseling for health providers
3. Manual on Community Mobilization for Participatory Development Planning
4. Training Module on Community Mobilization for Maternal and Child Health Program
5. Guidelines on Birth Preparedness and Complication Readiness with Sticker
6. Guide on MCH LAM (see discussion below on LAMAT)

The IMNCH Model covers elements that draw from BCC methodology to transmit messages about healthy practices and to engage families and communities in supporting application of healthy practices such as immediate and exclusive breastfeeding for the first six months, and routine hand washing with soap to decrease the incidence of childhood illnesses. As well as ensuring institutionalization of the approach, by embedding activities within the routine work of local partners, the Model shows how these activities can be funded and implemented through partnerships with the commercial and nonprofit private sectors. These activities included production of videos, media spots, and popular regional rallies in support of breastfeeding.

Creating Messages That Work

When the West Jakarta BCC Team started designing messages to promote breastfeeding, they first came up with slogans using proper Indonesian, such as "*Inisiasi Menyusu Dini*" ("Early initiation of breastfeeding"). But as this group of energetic women worked with HSP-supported facilitators, they started to get creative using Indonesian slang. While slang is not often used in government health promotion, it predominates in everyday conversation and, in a city like Jakarta, is ever-changing.

When the facilitators sat down with mothers to discuss breastfeeding, they jumped right into a discussion of what words most clearly communicated the concept of "breastfeeding within one hour after delivery." The mothers present said they felt most comfortable with less formal terms. And so, by the end of the session they were laughing and agreeing that the slogan, "*ASI Langsung, Langsung Aja…Gitu Lho*!" (Breastfeed immediately, Just Do It…That's The Way!) was the clearest and most attention-grabbing. The focus group also helped the BCC team identify the barriers they must address in order for mothers to change their breastfeeding behaviors. Most women had not heard of immediate breastfeeding from the sources they considered credible: their mothers, midwives and friends. The majority also believed that the difficulties of recovering from the delivery wouldn't allow them to breastfeed their newborn within an hour. Most simply thought they wouldn't have breastmilk in such a short amount of time. "How can we breastfeed," asked one mother, "when there's no breastmilk?" "When your baby is hungry in the first few days, it needs formula milk because the mother's breastmilk hasn't come in yet," said another. After completing the formative research, the BCC team concluded that they needed a "big moment" to kick-start the practice of immediate breastfeeding in West Jakarta. In addition to billboards, radio spots and training midwives to promote immediate breastfeeding, the team also got involved in registering the 1,001 pregnant women who pledged their commitment to breastfeed.

Table 6: Breastfeeding and Hand Washing Activities, 2006-2008*

Indicator	2006-2008
Number of regional trainers trained in immediate breastfeeding	31
Number of regional trainers trained in hand washing with soap	134
Number of CHC members in HSP villages trained in immediate breastfeeding	388
Number of CHC members in HSP villages trained in hand washing with soap	354

*From: *Health Policy Services Program Final Report*, p. 38

4. Strategic Improvements in Health Information

A key to effective planning is valid, timely, and complete health information. Therefore having quality data is integral to many elements of the IMNCH Model. HSP support did not address health information directly in early program phases, but under the extension sought to strengthen the quality of health information from the bottom of the system to the top through several strategic interventions.

HSP provided support to active surveillance through the LAMAT methodology and reactivation of the Maternal and Perinatal Audit system. Rather than trying to overhaul the entire HIS in efforts to make improvements, the IMNCH Model instead emphasized the use of data as central to every activity—from district planning to *puskesmas* service delivery to community mobilization. By providing data with a clear at active purpose, at the immediate level of collection, the IMNCH Model demonstrates the importance of data to partners. By providing this impetus, the Model tried to address some of the issues related to poor collection and reporting described in the situational analysis.

4.1 Local Area Monitoring and Tracking (LAMAT): At the frontlines of primary health-care, HSP supported the improvement of village health outcomes by focusing on surveillance under a methodology called LAMAT, which provides the data for village, sub-district, and ultimately, district planning and quality improvement of health services.

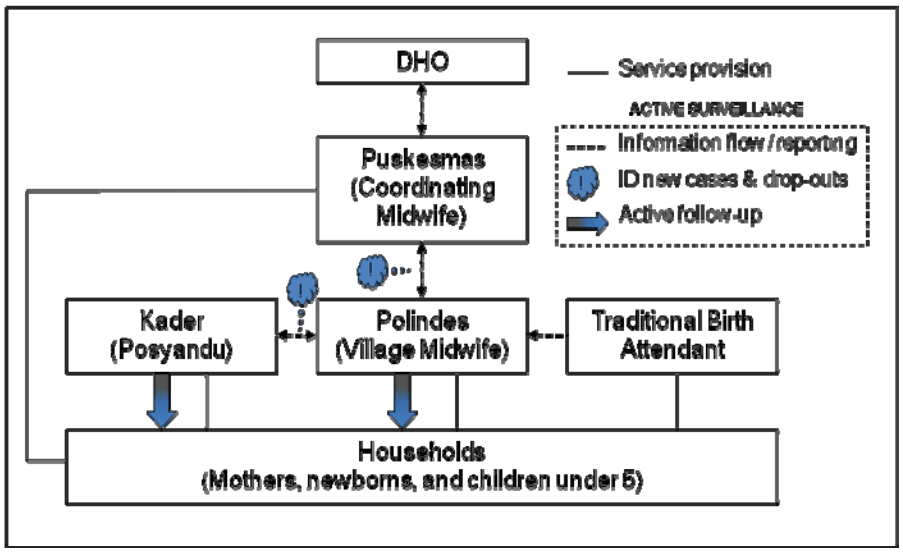


Figure 8: Active surveillance and follow-up under LAMAT[17]

HSP supported the introduction of an active surveillance approach to the existing health information system in order to improve the accuracy and timeliness of data collected, and to more effectively use data for monitoring, planning, and supervision. This process follows a fundamental principal of the IMNCH Model which is to build on rather than replace existing systems. Local Area Monitoring and Tracking (LAMAT) strengthened the MOH's existing Local Area Monitoring (LAM) system. Developed with funding from UNICEF, the MOH signaled support for replication and HSP supported this by integrating the use of LAMAT into the overall IMNCH Model.

The particular element strengthened by LAMAT over the previous approach was the introduction of an active surveillance approach to MNCH activities at all levels. HSP supported introduction of the system to two districts using computerization in one districts and by making simple adjustments to the use of the paper-based system in the other. While computerization has overall benefits for data collection and usage, it was found that the paper-based improvements were equally as useful in bringing about the key changes in use of data.

The primary focus of HSP support for LAMAT however was at the village level, where active surveillance was seen as a potential life-saving measure. Here, training was

[17] This diagram and the discussion are drawn from the HSP Case Study: Strengthening Active Surveillance and Data Use at the Community Level to Improve Maternal, Neonatal, and Child Health (pp5-6).

provided to the village midwife, *kader posyandu*, and traditional birth attendants to ensure the completeness and accuracy of MNCH recordkeeping, to do basic analysis on-site using the information at hand, and to formulate follow-up plans based on that analysis. Trainings for LAMAT were integrated with other component trainings (e.g. for P4K or *musrenbang*) so that activity implementation was always supported by data; very few stand-alone data activities were supported. Implementation was supported through monthly meetings of the village midwife with the *puskesmas* coordinating midwife and through supportive supervision (see discussion on page 40) from the *puskesmas* to the *polindes* and *posyandu.*

Under the LAMAT methodology village midwives and *kader* actively identify and monitor women, newborns and children in the village, and cross-check their information to identify new pregnant women and newborns as well as those, including children, who fail to appear at *posyandu* or for a scheduled check-up (known as "drop-outs"). Midwives and *kader* then work together with community leaders, traditional birth attendants, religious leaders or other relevant community groups to follow up, including by providing outreach to the household if required. In this way, a strengthened HMIS becomes part of a direct intervention for saving the lives of women, newborns and children at the village level. This approach extended a tradition long-tested in the area of infectious disease surveillance and immunization and was introduced to *kader* as a strengthening of their existing approach rather than an additional program or duty.

As well as identifying individual drop outs, at a systems level an active surveillance approach helps to pinpoint problems requiring follow up, lagging performance, and to plan for corrective action. This is a big advantage over the prior system which merely sent un-validated and incomplete information forward to the *puskesmas*, which in turn sent it forward to the DHO. The process at the village level is replicated at higher levels of care and feed into planning, monitoring, and supervision at the *puskesmas* and DHO.

Impact of LAMAT on Use of Health Information at the Village, Sub-District, and District Levels

Malang and Pasuruan Districts both reported they analyzed LAMAT data to monitor and routinely review the performance of MNCH programs at regular meetings (though written records of these meetings were not available). DHO staff were able to produce evidence of data analysis, including graphs charts and tables produced based on LAMAT data.

There were clear improvements in data analysis and use at all levels between the baseline and follow-up surveys. HSP assistance worked to strengthen performance through LAMAT training for key persons, support for evidence-based planning workshops using LAM data (DTPS), and through use of data to inform the activities of the district and sub-district Integrated MNCH coordination teams. Following LAMAT implementation, respondents reported that data were analyzed more routinely and in more detail. Both districts were better able to prepare action plans and motivate *puskesmas,* village midwives and *kader* to follow up with MCH drop-outs. Table 7 presents performance results related to use of information, and Table 8 highlights improvements in action plan preparation reported in response to open-ended questions.

Table 7: Use of information

Indicator	Village				Sub-district				District				Total			
	Base*		F/U**		Base		F/U		Base		F/U		Base		F/U	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Monthly performance review meetings	38%	(8)	100%	(8)	50%	(6)	100%	(6)	0%	(2)	100%	(2)	38%	(16)	100%	(16)
Action plan developed based on data	25%	(8)	50%	(8)	33%	(6)	83%	(6)	0%	(2)	100%	(2)	25%	(16)	69%	(16)
Evidence of data use and display	38%	(8)	100%	(8)	33%	(6)	83%	(6)	0%	(2)	100%	(2)	31%	(16)	94%	(16)
Follow-up actions taken	25%	(8)	88%	(8)	50%	(6)	100%	(6)	0%	(2)	100%	(2)	31%	(16)	94%	(16)
Results dissemination to stakeholders	N/A	(0)	75%	(4)	N/A	(0)	67%	(6)	0%	(2)	100%	(2)	0%	(2)	75%	(12)
Evidence information used to seek additional funds	0%	(4)	88%	(8)	17%	(6)	100%	(6)	0%	(2)	100%	(2)	8%	(12)	94%	(16)

* Base: Baseline; ** F/U: Follow-up

Table 8: Changes in preparation of action plans following LAMAT implementation (follow-up survey only)

Respondent cadre	Response to open-ended question (N)
Puskesmas (n=6)	▪ Action plan development started / now more detailed (5) ▪ More emphasis on tracking & follow-up for drop-outs (2)
Village midwives (n=4)	▪ More clear what to do (1) ▪ Now done monthly instead of annually (1) ▪ Action plans developed for first time (1)
Kader (n=4)	▪ Better / more active (2) ▪ Action plans developed for first time (1) ▪ No change (1)

From: *Strengthening Active Surveillance and Data Use at the Community Level to Improve Maternal, Neonatal, and Child Health,* p.23

4.2 Maternal Perinatal Audit (MPA): It is national policy in Indonesia to conduct a verbal autopsy for every maternal and perinatal death. However, they are not consistently done in many areas, and districts often lack experience in using the results to identify appropriate corrective actions. HSP provided support to the district government to activate the MPA system to conduct verbal autopsies for every death, whether in a facility or in the community, and to analyze and use the results to prevent future cases.

Tool for the Maternal Perinatal Audit (MPA)

Technical Guidelines for Maternal and Perinatal Audit for Districts & Municipalities

The Maternal Perinatal Audit (MPA) is an activity for tracing back the causes of maternal and perinatal morbidity and mortality to prevent future cases. This activity helps health personnel to determine the conditions that resulted in the mortality/morbidity. The MPA can also function as a monitoring and evaluation tool of the referral system.

The process is led by an MPA Team, which is a sub-team of the overall MNCH District Team. Participants are draw from the DHO and district hospital. The teams play a central role in ensuring that deaths are actively detected and verbal autopsies are carried out for as many deaths as possible, and that the results are reviewed and used for decisionmaking. HSP provided initial support to the DHO to establish the team and to orient hospital, *puskesmas,* and district staff on national MPA guidelines and plan for the implementation of verbal autopsies for deaths recorded at the community level.

Once the system is activated, autopsies are conducted as soon as deaths are reported to the health system, whether through the village midwife or *puskesmas*, the private sector, or the routine health information system. For deaths that occur in the hospital, district officials complete the MPA using hospital records. Verbal autopsies are normally led by the coordinating midwife from the *puskesmas* and the village midwife from the community where the death occurred, with support from the District Health Office.

Routine reviews of verbal autopsy results are conducted to identify systematic problems and corrective actions. Approximately twice a year, the district team leads a review of selected cases, held at the village, sub-district, and district levels. At the reviews, circumstances surrounding deaths are discussed and common problems are identified. Corrective actions that can be taken to prevent such deaths in the future are identified and follow-up plans developed.

As part of activating the system, HSP provided support to the DHO in both districts to develop an addendum to the MPA district guidelines including more detailed implementation guidance, particularly for conducting routine reviews of MPA results. HSP also helped to develop a series of checklists to assess implementation at the village, sub-district, and district levels, and provided operational support for conducting the reviews.

Maternal and Neonatal Deaths Audited in Malang and Pasuruan Districts in 2010

Thirty-two **maternal** deaths occurred between January and May 2010 in Malang and Pasuruan. Of these women around 60% were under 30 years of age and 40% were over, with around half having an education level of primary school or lower. Almost all of the deaths occurred at the hospital or in transit (71% hospital, 23% in transit) and postpartum hemorrhage and eclampsia accounted for 67%. Twenty-eight patients sought a referral and of those, 64% went to two or more locations with 46% seeking care at three locations. The average time between seeking care at the first location and receiving care at the final location was 8.9 hours.

There were 193 **neonatal** deaths in Malang and Pasuruan between January and May 2010. Around 70% of the mothers were under 30 years old and 40% were under 25. Around half of the mothers had primary school or lower education and only 18% had completed high school or a higher level of education. 57% of the infants who died were male and most of these died within the first seven days (49%) or were stillborn (37%). The most common places of death were the hospital (58%) and at home (28%) and asphyxia and low-birth weight accounted for around half of the deaths. There were 147 infants with a referral and of these 57% sought care at two or more locations. The average time between seeking care at the first location and receiving care at the final location was 6.8 hours.

D. Improvement in the Availability and Quality of Services

Maternal and neonatal mortality are influenced by a multitude of interrelated social, behavioral and clinical determinants, and the availability, quality, and utilization of health services. The relationships between these elements are complex and not reducible to a simple explanation. Yet despite this complexity, there is now international consensus that access to skilled obstetric care around the time of birth, including comprehensive emergency obstetric and neonatal care (CEONC) is essential for reducing maternal and neonatal mortality.[18]

The HSP IMNCH Model puts into practice three valuable lessons, learned over the last 20 years, which have informed the consensus. The first lesson is that reducing maternal and neonatal mortality requires ensuring women have timely access to quality emergency obstetric and neonatal care (EONC) as every pregnancy entails risks that can develop into life-threatening complications for the mother and/or baby. Because many life-threatening complications are neither predictable nor preventable, it is critical all pregnant women have access to skilled birth attendants, who can recognize complications when they occur and make informed decisions to refer women or newborns with complications to EONC services.[19]

[18] Basic emergency obstetric and neonatal care (BEONC) includes providing parenteral oxytocin, antibiotics and sedatives. It also covers postabortion care, manual placenta removal, forceps and vacuum extraction, prevention of newborn hypothermia and newborn resuscitation. CEONC includes BEONC services plus cesearean section and blood transfusion capabilities.

[19] Maternal mortality: The principal causes of maternal death in virtually every country where maternal and neonatal mortality and morbidity remain high are hemorrhage, eclampsia, infection, obstructed labor, and unsafe abortion. Effective response to these life-threatening complications requires a skilled provider capable of detecting complications immediately, stabilizing the woman for transport to a BEONC level facility, and having timely access to a CEONC level of care if a c-section and blood transfusion is necessary. Neonatal mortality: Newborns die principally of asphyxia, pre-term births and infection. In the

A second lesson is that skilled care is only effective if it is part of a functioning healthcare system that links women and newborns to higher levels of care when needed. A functioning system requires that healthcare services adhere to national clinical guidelines that meet international standards for EONC and skilled birth attendance. A functioning system also depends on policies that support training and rational deployment of healthcare professionals, especially those with midwifery skills, throughout the country.

The third lesson is that it is essential to have reliable information about the causes and circumstances surrounding maternal and neonatal deaths in order to know what kind of improvements are needed in the health system to ensure women's and newborns' access to life saving care when complications arise. Interventions on this element of the IMNCH Model have been described under support for Maternal and Perinatal Audits, above.

1. Clinical Capacity Building and Quality Improvement

Under the IMNCH Model, the need to improve clinical capacity is assumed. As this can be a potentially overwhelming area for support, investments should be made according to an assessment which weighs the causes of deaths against the most effective responses. During the life of HSP, the initial program phases provided support to a number of areas of clinical capacity improvement, particularly at the level of primary care. By the extension phase however, this support was assumed to be the sole responsibility of the implementing district, with HSP assisting the DHO in planning and budgeting for sustainable programming. Under the extension, HSP turned attention to strategic improvements in hospital care for mothers and neonates, with a focus on emergencies.

Emphasis on the use of data is also critical to all of the clinical quality improvement activities. Interventions supported under the IMNCH Model not only demonstrate how accurate data improves the quality of the service, but the data generated is cycled back into the broader planning cycle, improving the evidence basis for the overall plans.

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case of newborns, interventions can be initiated by a skilled provider trained in newborn resuscitation and the importance of skin to skin contact prior to, and during transport to a higher level of care.

Table 9: Overview of Achievements in Provider Training*

Indicator	2006-2010
Number of people trained in APN package	7,025
Number of people trained in PONED	895
Number of people trained in PONEK	520
Number of people trained in CTS	115
Number of people trained in P2KS/P refresher in AMSTL, BF	1,421
Number of people trained in the use of IMCI modules (including DHO, PHO, and *puskesmas* staff, as well as health providers and trainers)	389

*From: *Health Services Program Final Report*

1.1 Normal Delivery Care (APN): The IMNCH Model recognizes the need for in-service training for midwives in normal labor and delivery care that incorporates active management of the third stage of labor and immediate breastfeeding. Normal Delivery Care (APN) training promotes training and certification of midwives and *puskesmas* providers to increase adherence to evidence-based practice. The APN training package emphasizes routine use of Active Management of the Third Stage of Labor (AMTSL), promotion of immediate breastfeeding, and adherence to standard clinical practices endorsed by the WHO for attending both home and facility-based deliveries. The package includes four days of classroom training and six days of practical training where trainees must supervise actual deliveries. This is a vital element of the model, as much pre-service midwifery education in Indonesia does not include clinical practice. Training is followed by an evaluation and accreditation process for both midwives and facilities. HSP provided support for training and certification of APN trainers using a competency assessment, as well as accreditation of health facilities at the district level.[20]

Private midwives can also participate in the training and become certified by paying a fee covering the cost of the course. HSP supported quality improvement for private midwifery by working with the *Bidan Delima* private midwifery quality improvement program of IBI to revise guidelines and standards to ensure that all accredited midwives were proficient in APN. HSP also partnered with the private sector to leverage support for the training of private midwives as part of the *Bidan Delima* component.

Training Manual for Normal Delivery Care

APN standardized training manuals for health providers attending normal deliveries in different levels of health facilities.

1.2 Integrated Management of Childhood Illnesses (IMCI): The IMNCH Model also includes GOI MOH standards to strengthen IMCI through training and assessment. In early phases of HSP, these standards were updated with program support to include protocols and algorithms for the neonatal period. Under the IMNCH Model, training in

[20] In addition, HSP strengthened a number of tools, training manuals, and protocols for the midwives. These are listed in Annex 1. See the MOH's Guidelines Basic Midwifery Services based on Human Rights and Gender Fairness.

IMCI is provided to *puskesmas* staff to improve treatment of major childhood illnesses, including respiratory infections and diarrhea. In addition to increasing the skills of local health providers in line with the WHO protocol for managing illnesses in children under 5, the IMCI module includes guidance on how to conduct assessments at the *puskesmas*, district, and provincial level. The assessment piece of the module helps healthcare providers to identify gaps in implementation and correct practice of the protocol. The IMCI module includes a series of assessment tools which are used to identify needs for providing appropriate care for childhood illnesses. An initial "IMCI mapping" exercise assesses important aspects of service delivery including human resources, drugs, tools, budget availability, and the current implementation process. Training for doctors, nurses, and midwives follows the assessment phase. Following the training, qualification and accreditation tools, developed by the MOH, are used to assess and accredit health facilities that demonstrate competency in the application of IMCI. The assessment phase can also provide valuable data for inclusion in *puskesmas* and DTPS planning.

Tools for Integrated Management of Childhood Illnesses (IMCI)

1. Facilitator's guide to the IMCI Module
2. Module 1 Introduction
3. Module 2 Evaluation and Classification of sick children age 2 months to 5 years
4. Module 3 Determine Action and Administration of Medication
5. Module 4 Counseling for Women
6. Module 5 Integrated Management of Newborn younger than 2 months old
7. Module 6 Follow up
8. Book on Photo Collection
9. Book on Charts of the Integrated Management of Childhood Illness
10. Recording Forms

1.3 Supportive Supervision: Supportive supervision is one of the most important activities for improving health service quality, with respect to both specific clinical and non-clinical procedures as well as to general management and supply issues. HSP supported development of the tools and modules for supportive supervision.

Supportive supervision ensures that birth attendants are skilled and perform to standards taught through APN training. It also enhances the implementation of other interventions previously supported by the IMNCH Model, such as technical training for APN, IMCI, and nutrition/breastfeeding. The supportive supervision package consists of training for MNCH program managers and midwife coordinators at the district and sub-district levels, and for *puskesmas* directors. The training enables supervisor-level midwives to supervise other midwives at the *puskesmas*, in villages (at *polindes*), at health posts serving several villages (at *pustu*), and in private practice. The supporting materials include a reference guide on supportive supervision; handbooks for trainers and for participants; a reference book on data collection and on the health information management system; and separate checklists for *puskesmas* with beds and without inpatient care, for village midwives in *polindes* and for private midwives. The checklists focus on MCH, FP, and delivery care.

Under the HSP extension phase, the supportive supervision methodology was also used to improve performance in other areas related to MNCH. One innovation was the application of supervision so that *puskesmas* began more closely supervising the performance of the *posyandu*. Similarly, HSP supported district health officials to expand the use of the supportive supervision approach to cover supervision of the LAMAT data collection system.

Supervisors conduct regular meetings at the *puskesmas* to discuss relevant elements of performance. In particular, supportive supervision checklists are used to identify gaps at the *puskesmas, pustu*, *polindes,* or *posyandu* and to determine corrective actions for improving the quality of services.

Tools for Supportive Supervision

1. Reference for Maternal and Child Health Program Supportive Supervision
2. Handbook for participants of the MCH Program Supportive Supervision
3. Handbook for Trainers of the MCH Program Supportive Supervision
4. Reference for Management Information System (Software to process the MCH Data)
5. Checklist for *Puskesmas* with in-patient care, Supportive Supervision for MCH, FP, and Delivery Care Services
6. Checklist for *Puskesmas*, Supportive Supervision for MCH and FP Services

1.4 PONED – Basic Emergency Obstetric and Neonatal Care (BEONC): The IMNCH Model supports increased coverage of PONED (*Pelayanan Obstetri dan Neonatal Emergensi Dasar*) competency-based training to improve access to quality Basic Emergency Obstetric and Neonatal Care at the *puskesmas* level. These include evidence-based interventions that do not require an operating room or blood transfusion, including assisted delivery, administration of parenteral oxytocics and anticonvulsants, manual removal of the placenta, and removal of retained products. The MOH PONED training package assesses and improves the skills of *puskesmas*-level providers to provide first line care in the event of obstetric and neonatal emergencies. The package increases practice of evidence-based interventions for the major causes of maternal mortality in Indonesia, including hemorrhage and obstructed labor, and treatment of neonatal asphyxia and infection. In addition, training reinforces practices for stabilization, transportation, and referral in cases where more comprehensive care is required. PONED also includes qualification and accreditation standards, as well as tools for monitoring and evaluating providers on adherence to standards of care.

Tools for BEONC

1. Training manual for standardization and implementation of Basic Obstetric and Neonatal Emergency Care for health providers
2. Training manual for standardization and implementation of low birth weight (LBW) management for village midwives
3. Training manual for standardization and implementation of asphyxia management on low birth weight infants for midwives
4. This book provides guidelines for assessment and management of sick babies under two months of age.
5. Guidelines to Develop Basic Emergency Obstetric and Neonatal Care (PONED) (Ministry of Health, Republic Indonesia, 2004)

2. Improved Quality of Care in Hospitals

The IMNCH Model includes a process for improving quality of maternal and neonatal emergency care in hospitals. At the beginning and end of the project, HSP worked in selected district and provincial hospitals to strengthen delivery of comprehensive emergency obstetric and neonatal care through improvements in updating of technical procedures and on-the-job training and support. In addition to the evidence-based guidelines and protocols, this piece of the model focuses on improving infrastructure, implementation of the protocols, and accountability through recordkeeping and audit procedures for greater accountability.

The interventions promoted as of highest priority under the IMNCH Model utilize four main approaches which are essential to improve the quality of hospital services for mothers and newborns:

1. Clinical and in-service training,
2. supervision,
3. hospital management, and
4. adherence to standards of care.

Hospitals play a critical role in the district referral system in ensuring the availability of appropriate care for women and children. Support for the hospital sector has often been viewed with some wariness by donors given the complexity of the issues involved. The IMNCH Model cuts across this complexity by prioritizing three programs which address essential components of hospital care for the mother and newborn – PONEK (CEONC), MNERC (Maternal Neonatal Emergency Room Care), and KMC (Kangaroo Mother Care) – and reinforces the role of professional associations in increasing adherence to standards of practice.

HSP supported Government of Indonesia's efforts to revise national policies, standards of care, and protocols in line with internationally recognized evidence-based practices. This comprehensive package of national standards, guidelines, and protocols are part of the Ministry of Health MNCH Toolkit.[21] These include national guidelines for referral and counter-referral.

[21] A complete list of these tools is found in Annex 1.

2.1 PONEK- Comprehensive Emergency Obstetric and Neonatal Care (CEONC): The resolution of obstetric and neonatal complications during pregnancy, delivery, and postpartum are front and center in the IMNCH package of interventions. In 2006-2007, HSP provided technical assistance to revise and update the Comprehensive Obstetric and Neonatal Emergency Care Package, or PONEK (*Pelayanan Obstetri dan Neonatal Emergensi Komprehensif*), in line with international standards. The PONEK package, which targets doctors, nurses, and midwives across the hospital responsible for MNCH care, includes protocols and instruments for on-the-job training and supportive supervision of practitioners once they've been trained, and also tools for assessing the implementation of clinical standards of practice. The package also has a strong neonatal care component, developed by the Indonesia Pediatrics Association (IDAI) with support from HSP.

Tool for Comprehensive Emergency Obstetric and Neonatal Care

PONEK Training manual for standardization and implementation of Comprehensive Obstetric and Neonatal Emergency Services

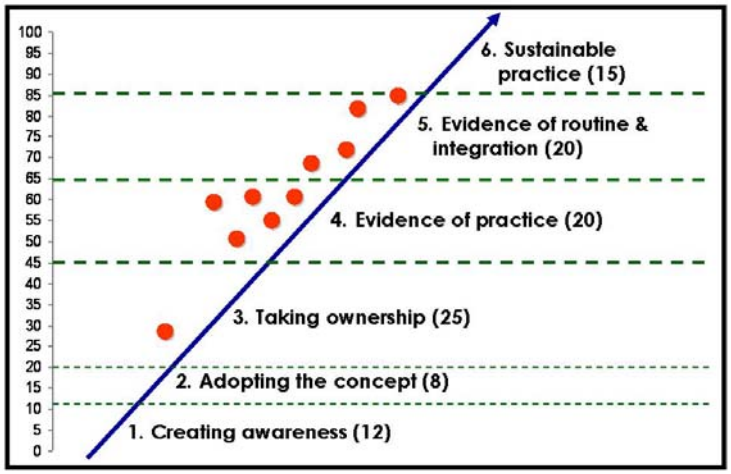
2.2 Kangaroo Mother Care (KMC): To improve care for premature and low birth weight infants, PONEK training was complemented by scaling up the use of Kangaroo Mother Care (KMC). KMC is an effective, evidence-based approach that has been used in a variety of international settings to improve underweight and premature infant care without the use of an incubator (Bergh et al, 2005). Incubators in developing countries are often an unreliable way to treat premature and low birth weight (LBW) babies as, often, they are unavailable, not adequately maintained, or used incorrectly. To address the greatest causes of infant mortality in Indonesia, complications from low birth weight and malnutrition, and to improve the use and quality of KMC, HSP, in conjunction with the Indonesia Association of Neonatologists (Perinasia) and the MOH, introduced KMC in ten hospitals. Later as part of IMNCH modeling, replication was supported at the regional level, using Saiful Anwar as the regional training center (see MNERC section below). Hospitals were seen as a key entry point to introduce the practice to providers and mothers, rather than communities as community-based care cannot succeed if the higher levels for referral are not already in place. The approach involves a training program targeting midwives, nurses, and doctors in the neonatal ward of the hospital, followed by on-the-job training from Perinasia staff to reinforce correct practice, and help the hospital to identify any needed equipment or changes in hospital procedures to support KMC. Separately to that conducted through HSP programming, the MOH has supported the scale up of KMC through training conducted by Perinasia.

Implementation of Kangaroo Mother Care

HSP worked with Perinasia to support and document scale up of KMC in 2009-2010 in 10 hospitals across Java, with technical assistance from a worldwide KMC expert. Baseline and endline assessments allowed for scoring the progress of implementation of KMC in each hospital.

An analysis of these assessments found that nine out of the ten hospitals trained were successfully implementing KMC by the end of the project, including four facilities (two of which were training centers) that were approaching integration and sustainable practice. Findings showed that KMC was well-accepted and supported in most settings by hospital staff and patients. Better integration of services between different health authorities, and both between and within health facilities, is still needed however to overcome general weaknesses in the health system that result in poor continuity of care, especially for post-discharge follow-up of low birth-weight babies.

Figure 9: KMC implementation progress in ten hospitals



To support future scale up of KMC in Indonesia and maximize the impact of the approach, the study recommended strengthening the hospitals implementing KMC *before* larger scale-up initiatives or the introduction of KMC at the community-level. In addition, it was recommended to develop a model for the scale up of KMC that builds on the existing health system. The model would include a provincial teaching hospital that serves as a center of excellence for future training and supervision of district hospitals and that is also used as referral points for step-down facilities such as the *puskesmas*, *polindes*, and *posyandu*.

*From: *Final Report Kangaroo Mother Care*

2.3 Maternal and Neonatal Emergency Room Care Activities Indonesia (MNERC): At many district hospitals, emergency rooms are not properly equipped or trained to handle obstetric and newborn emergencies, and front-line providers are often not authorized to provide emergency care without an obstetrician or neonatologist present. Often, such cases are not even assessed before they are sent up to the obstetric or neonatal ward, and poor coordination between wards often leads to further delays in receiving life-saving care. HSP-supported assessments in several district hospitals in 2010 revealed that obstetric or neonatal doctors were not always available, and ward staff in charge had little expertise in or access to adequate resuscitation equipment, and no standing orders to provide emergency care.

Maternal and Neonatal Emergency Room Care (MNERC) is aimed at improving management of obstetric and neonatal emergencies. Specifically, MNERC address the frequent problem that obstetric emergencies upon arrival are shifted directly to the obstetric or pediatric ward without any triage in ER and without ensuring availability of expert help. These departments are receiving the women and babies, often without having the 24 hour coverage of staff skilled in CEONC, thereby delaying necessary life-saving care for mothers, fetuses, and newborns.

The MNERC program expands the focus outside the neonatal and obstetric ward to improve overall hospital management of emergency complications. While PONEK focuses on overall capacity within the hospital to provide emergency care, this emergency room training program reinforces another fundamental tenet of the IMNCH Model, that "Every Minute Counts" when a mother or infant arrives at the hospital with a complication. For that reason, MNERC emphasizes the role of the emergency room in providing first-line care, and helps hospitals to look critically at their procedures and readiness to ensure critically ill mothers and newborns are assessed and stabilized while they waiting to be attended by a specialist.

The MNERC methodology works within the system to strengthen existing and potential resources. It adopts a strategic approach that focuses on the simplest interventions that are likely to have the largest impact on maternal and neonatal outcomes. MNERC provides both emergency room and specialist staff with an orientation to standards of care for emergency cases, and provides support to hospitals to assess and improve their procedures for management of obstetric and neonatal emergencies through routine self-assessments, clinical training for emergency room staff, to be followed up with on-the-job training.

The MNERC process entails a series of strategic steps:

- Strengthen and support the regional training center (clinical protocols, materials, training methodology)
- Conduct an initial assessment of the district hospital and identify weaknesses and strengths
- Assist in the development of a priority-based facility self-improvement plan
- Perform clinical and managerial monitoring
- Establish a feedback reporting system between district and regional teaching hospitals
- Provide data and reporting system to the Provincial Health Authorities
- Develop a sustainability plan

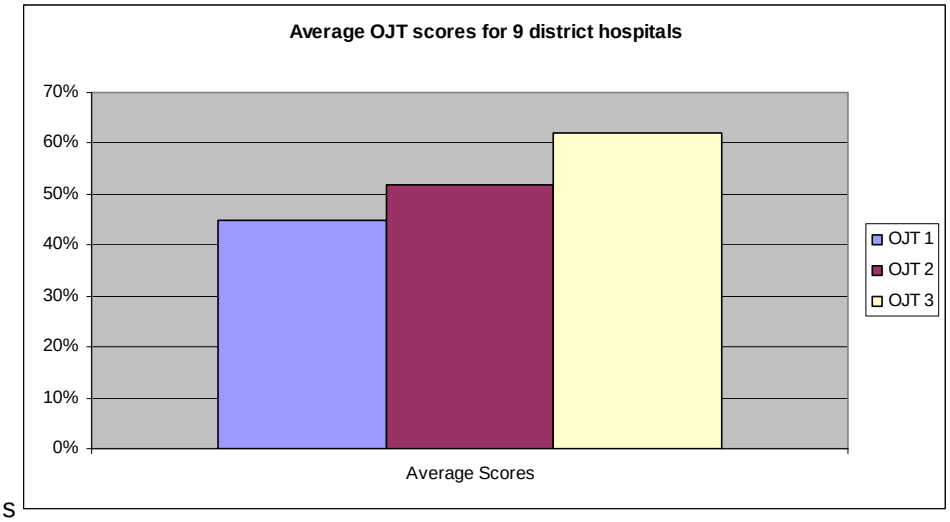
The outcome should be procedures with triage for all obstetric emergencies in the ER, so that women with life-threatening conditions are immediately attended by senior ER physicians and resuscitation is started. An obstetrician should be called as soon as possible. The woman should not be shifted to obstetric care until she has been stabilized. Once established at the hospital, the skills should be transferred to the EMTs so that emergency life saving and obstetric stabilization procedures should begin in emergency services such as ambulances and primary care centers.

Results of Improving the Quality of Maternal and Neonatal Emergency Room Care (MNERC)

MNERC activities supported by HSP made important strides—in complement to the PONEK and PONED training programs updated and revised with HSP assistance—toward beginning to change the culture of emergency care in district hospitals, and ensuring mothers and children can access prompt, life-saving care, day or night. After reviewing and clarifying national protocols with respect to management of obstetric and neonatal emergencies by non-specialists, some 429 hospital staff from 22 districts were trained in MNERC protocols. The protocols were then used to develop a full emergency room improvement package—17 trainers were trained followed by two additional trainings for 28 participants with HSP assistance—and implement it with Saiful Anwar Provincial Hospital serving as a regional training center. The process includes technical assistance to participating hospitals to conduct an initial clinical and managerial assessment, develop a facility self-improvement plan, and establish ongoing training, feedback, and reporting systems through the regional training center.

In response to this, HSP worked with the Indonesia Society for Perinatology (Perinasia) to review the protocols, standards, and standing orders that would be required for emergency room personnel to deliver obstetric and neonatal care and with the Saiful Anwar Hospital to build a regional model for training and supervision. This approach strengthens the existing system as regional referral hospitals have the duty to train and supervise staff from other district hospitals in the region: the Saiful Anwar hospital supervises nine district hospitals. The approach is a competency model, which includes measuring success against self-improvement plans from baseline assessments.

Initial results of on-the-job training conducted between July and September in the nine district hospital show a marked improvement in adherence to standards for emergency care of maternal and neonatal cases.



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Quality and Access to Perinatal Emergency Care (QUAPEC)

As part of the diagnostic foundation of the IMNCH Model, HSP worked with the University of Indonesia on QUAPEC—or Quality and Access to Perinatal Emergency Care—at the district level, an in-depth observational study on the quality of care provided to pregnant women and newborns in two district public hospitals. The purpose of the study was to examine obstetric outcomes, the quality of care provided to women and newborns, and the impact of maternal risk on neonatal outcomes at public hospitals. The study includes detailed analysis of 1258 medical records retrospectively and 1240 prospectively, covering all obstetric and neonatal admissions over a 12-month period, and direct observation of care provided for obstetric and neonatal cases in both routine births and for key complications. The study provides detailed information on the care provided, the characteristics of public hospital users including method of payment information, and makes a significant contribution to the knowledge base on hospital care in Indonesia by directly linking the care of the mother to the care and outcomes of the infant.

The findings provide a strong rationale for interventions supported by the IMNCH Model. The findings of the obstetric outcomes study reinforce the need for:

- Special attention to increasing the capacity of physicians, midwives, and nurses on treatment protocols for the management of antepartum and postpartum hemorrhage and pre-eclampsia.
- Training of primary care health services on early recognition and appropriate referral of complications
- 24/7 coverage of BEONC and CEONC services

The second study examined quality of care after hospital staff had been trained in PONEK (CEONC). It found that there were major gaps in standards of care and their correct implementation which argues for a need for more directed competency-based training, including:

- Clear benchmarks for mastery of clinical competencies and practices
- On-the-job training, with ongoing supervision and re-training
- Better connection between national standards and professional certification and accreditation requirements

The final study examined the impact of maternal characteristics and perinatal complications on neonatal outcomes, by studying 650 maternal/single birth live born pairs and 49 maternal/stillborn pairs. The findings revealed that babies of poor young rural mothers with little education are most at risk, especially when their mothers arrive at the hospital with severe and advanced complications, such as postpartum hemorrhage. Babies of women referred by another health facility are at less risk than babies of women who refer themselves. The conclusions are that there is a need for services that are better targeted to poor young rural women and their families.

3. Availability

In addition to supporting improved quality of services, the IMNCH Model also addresses availability and access to services. As highlighted in the QUAPEC studies and the MNERC assessments, lack of a well functioning referral system and insufficient numbers of obstetric and neonatal specialists contribute to Indonesia's and other countries' high rates of maternal and neonatal mortality.

Referral is a critical issue. Given that 60% of Indonesian women still give birth at home, it is important that families know where to go in case of an emergency, and to ensure that the facility chosen has the capacity to respond with appropriate quality of care or to continue to the chain of referral to higher level care in a timely fashion. The IMNCH Model is predicated on good referral. HSP supported some aspects of work for the

strengthening of the referral system, however insufficient time remained to take the next steps.

Referral is an implicit aspect of the community mobilization elements of the model. The P4K program includes, as part of the general birth planning, actions to be taken in case of emergency, including transportation should the need arise. In addition, HSP experience determined that recognition of danger signs remained weak, so in the final refresher training for facilitators and *kader,* a special focus was incorporated as part of the course. Information was drawn from existing MOH guidelines and a pictorial tool for training communities distributed to midwives.

At the level of clinical referral, the Maternal and Perinatal Audit Guidelines form part of the national referral guidelines. These were reviewed and strengthened, particularly providing guidance for district implementation, with HSP support. As well as the study results, the audits were instrumental in pointing out to district authorities the gaps in the referral system. In some cases, over six hours passed between a woman first seeking care and her eventual admission to the hospital.

From the experience of HSP, reactivating the MPA is the first step for strengthening the referral system. By including clear time recording as part of the process, delays in the system can be more accurately captured. This provides the evidence not only to convince decisionmakers, but also the information required to identify the priority interventions that can have the biggest impact in improving the system. If time had allowed, the next steps for HSP would have been to facilitate partners to identify the problems at each level and how they could be resolved using existing district resources, or included in future DTPS plans. This is how the IMNCH Model works. Certainly, the district partners now have all the information they need to continue the strengthening as part of their own commitment to service improvement.

As for the shortage of specialists, this is a longer-term proposition and will be addressed over time at the national level. Some issues could be addressed through task-shifting and the MNERC has demonstrated that this can be done, however significant professional and legal issues will need to be negotiated in most cases.

RECOMMENDATIONS AND LESSONS LEARNED

The IMNCH Model is based on the premise that strengthening health systems is central to reducing maternal and neonatal mortality. Contrary to the perceptions of many skeptics that this is an overwhelmingly complex undertaking, HSP experience in supporting implementation of the IMNCH Model in Indonesia demonstrates that it is both feasible and effective, even in a highly decentralized health system.

The key components of an effective health systems approach are interventions that:

- Strengthen policy and political commitment at multiple levels of government, including evidence-based national health policies, standards, and protocols, and legal frameworks at the district (municipal) and village levels.
- Build capacity and accountability for planning and budgeting based on evidence-based practices and reliable demographic and health profiles of local populations.
- Strengthen the quality and reliability of health information through improved data collection, analysis, and reporting; active surveillance of pregnant women and newborns to ensure that services respond to their needs correctly and in a timely fashion; and use of data for planning and leveraging resources.
- Strengthen the skills and accountability of healthcare providers
- Strengthen systems that facilitate integration of health services at different levels (e.g., referral, logistics, communications, supervision)
- Engage civil society, and particularly local communities, in the design, implementation, and monitoring of healthcare.

HEALTH GOVERNANCE

1. Integrated programming as part of the decentralized health system should continue to be supported. The IMNCH Model provides guidance for this type of support.

The primary challenges toward reaching MDGs 4 and 5 in Indonesia have less to do with finding the right interventions than how to implement proven solutions within the system. There is broad consensus about the evidence-based programs and approaches needed to reduce maternal and child mortality, and the MOH has a wide variety of tools available. In the Indonesian context, however, the existence of a tool or program does not necessarily lead to implementation at the district level; challenges such as unclear authorities for health policy development, lack of capacity and resources, and lack of local political will at the local level present formidable obstacles. Yet in change there is opportunity, and evolving local autonomy also opens new potential for developing capacity and new approaches for health system development.

There is no “magic bullet” for strengthening district health systems, but a technical assistance model focused on the district health system can make a significant contribution. Under decentralization, districts play a central role in managing, funding,

and delivering health services. They exercise significant autonomy in deciding resource allocations and determining priorities in implementing national health policy, particularly at the community level.

Technical assistance must be tailored to local institutional realities and build on local leadership and lines of authority. Districts can vary widely in terms of the strength of local institutions, political will, and health system capacity and they need support in a variety of areas including management, supervision, planning, health information systems, clinical training, and community mobilization. The IMNCH Model supported by HSP provides a flexible framework that emphasizes the connection between interventions, but allows for individual approaches to be adapted to address gaps in specific district settings.

2. **Donor support should be focused less on providing additional financial resources and more on providing the kinds of technical assistance needed to help district stakeholders unlock local sources of funding.**

Diverse sources of funding are available, both public and private, that can be more broadly tapped and more effectively utilized to support MNCH. Decentralization has resulted in decentralized control over funding sources at virtually each level of government that can support health programming. Districts control a significant share of funding through central block grants and their own-revenues, and in some districts, user fees from health services are bringing in increased revenues controlled to varying degrees by implementing agencies. Village-level sources are also available. The emphasis on decentralization means that there is a window of opportunity to convince decisionmakers to use evidence-based and bottom-up planning processes.

3. **Continued support for local advocates will be needed to learn the impact of evidence-based planning interventions on local budgets; longer time horizons are needed to allow for the major shifts required to cement these approaches in local planning practice.**

HSP budget analyses have shown that while many districts have succeeded in pressing for increased funding for MNCH, there are many factors that influence district health budgets. Shifting the mindsets and practices of key decisionmakers in the district and *puskesmas* planning process to prioritize evidence-based—rather than politically expedient—activities is undoubtedly a longer-term effort.

HSP-supported tools including DTPS & advocacy modules, and PTP, provide guidance for planners and ultimately help to increase funding for MNCH programs. Continued support for advocacy as a key component of the DTPS approach, with a focus on building relationships and buy-in among key decisionmakers, should assist with moving to more evidence-based planning approaches. Expanded use of the enhanced PTP method—based on DTPS—to improve *puskesmas* planning capacity will help *puskesmas* managers implement changes in accordance with priorities identified.

4. The passage of district and village-level regulations on MNCH programming provides a strong basis for sustainability.

Regulations such as *perda* and *perdes* lock in long-term commitments from local officials to support MNCH programs. HSP experience indicates that these legal instruments are providing decisionmakers with a reference to justify and support changes in MNCH programming, including increased funding. In the decentralized health system, the passage of such regulations has proved to be an effective tool for institutionalizing a commitment to MNCH in district government policy.

Sustainability is also supported through the integration of the various district planning cycles to help ensure ongoing support for MNCH planning and budgeting. This can be achieved by ensuring that DTPS plans form part of the broader health plan or strengthening the linkages between technocratic planning processes and the bottom-up *musrenbang* planning system as a component of planning interventions.

Future options could include expanding the DTPS approach beyond MNCH to all health planning; feedback from many district health planners suggests this would be the logical next step for improved evidence-based planning across the sector. Future support should also assist districts to expand the time horizon of evidence-based planning to a medium-term plan (five years) in order to improve sustainability and a focus on health outcomes.

5. Strengthening both the availability and use of health data within the district health information system should be a key priority for improving evidence-based planning.

Data and information are important as the basis for performance-based budgeting, but there are significant reasons for concern about the quality of data from the district HIS. DHOs are often registering only a small portion of maternal deaths which other sources have shown are occurring. The MPA system is not functioning in many areas, and even where it is conducted, it may not necessarily be linked to problem identification and corrective actions. HSP experience has shown that technical assistance can improve the tracking of maternal and neonatal deaths through MPA and stronger routine surveillance data through LAMAT and community active surveillance. By focusing on use of data, whether through DTPS, *puskesmas* planning, or active surveillance at the community level, the importance of data is made real to stakeholders. These interventions encourage real-time use and analysis of data not just for district planning, but for active management of MNCH programs by providers at the village, sub-district, and district level.

6. The implementation of MNCH regulations should be the framework for donor support at sub-national levels.

MNCH regulations provide guidance to donors and other possible supporters (including from within the Indonesian health system) as to local needs and priorities in achieving

better health for women, babies and children. By structuring support through such regulations, the political commitment needed to tackle more challenging program aspects is ready. Furthermore, the regulatory framework covers multiple aspects of the health system at district level and below; this provides an opportunity for supporting that system, rather than isolated clinical or governance interventions.

The HSP case studies found that a combined approach benefits from synergies between each individual area of health system strengthening. Appropriate planning and budgeting for MNCH services cannot be undertaken without accurate and timely local MNCH information. By both strengthening capacities in LAMAT implementation and providing complementary planning assistance to implement DTPS and PTP, HSP was able to support districts in closing gaps between the local HIS and planning and budgeting from the village level (through village midwife/*kader* participation in local *musrenbang* fora) upwards (such as the review of LAMAT data by DTPS teams to determine district-level MNCH priorities and budgets need to address them). Similarly, evidence-based budget requests are not likely to be accepted by decisionmakers for funding unless there is high-level commitment to addressing MNCH. By institutionalizing a focus on MNCH through local-level regulations, districts have been able to garner such interest and priority-setting support.

7. Support to national and provincial levels should focus on the role of these levels in stewardship, technical support and oversight of district implementation.

Technical ministries have an important role in setting technical direction, providing tools and guidance, and implementing targeted vertical programs—but they have limited authority over district governments. The MOH has signaled that issues of accreditation and regulation will be increasingly important within the term of the current government. Donor support could assist officials at all levels to clarify roles for oversight and support to ensure districts, while setting priorities within the limits of their authority, are also delivering health services according to the Minimum Service Standards.

8. The Corporate Social Responsibility (CSR) law requires that the private sector contribute to social development; this opportunity should continue to be supported by future programs.

There is great interest in garnering private support for health programs. Efforts to strengthen problem analysis and planning at all levels can be extended to assist partners to propose support for activities to appropriate local partners. This can happen from the national right down to the village level. Capacity needs to be built within the health system to understand the interests of the private sector and how they intersect with the needs of the community.

CLINICAL QUALITY

9. While the Ministry of Health has adopted best practice policies in many key interventions areas, some practices need additional reinforcement before they will become part of the districts' mainstream programs.

More work is needed to convince districts on the effectiveness of a number of key MNCH interventions as they are not yet routinely incorporated into plans. Support for Active Management of the Third Stage of Labor, immediate and exclusive breastfeeding, and the new MOH protocols for newborn care are critical examples. New tools or policies are not required; efforts should be made to ensure that sufficient funding is available in district budgets for upgrading midwifery skills where required.

The most effective approach to improving clinical practice under a health systems strengthening approach is via supportive supervision, both as a means of introducing new practices and of reinforcing them. Implementing supportive supervision at all levels and peer-to-peer support and replication also increases the performance of the institutions and encourages effective communication and better partnerships between *puskesmas* staff, *bidan desa,* and *kader.* Donor support for improved clinical approaches should also support implementation through this modality.

10. Partnerships with professional associations should be encouraged as these groups play a key role in strengthening quality and adherence to standards in training and care.

Professional organization can lead acceptance of methods to improve the quality of care, both in the private and public sectors, but need further support to play that role. Professional associations such as Perinasia, IDI, POGI, IDAI, PPNI, IAKMI and, especially, IBI, played a central role in HSP-supported clinical training and assessment activities, both at the hospital and community level. These groups have significant clout with the MOH and also wield great influence over providers through control of membership. As a national training network center, JNPK plays a role in national training and certification programs. Indonesia's professional associations are not yet systematically using that influence to reinforce development of, and adherence to, national standards, but could be leveraged to play such a role.

Future programs should continue to strengthen the role of IBI. Midwives are a major provider of MNH services especially at the community level and in private practices. IBI is an association of over 70,000 public and private midwives and thus are a potential force for improving maternal and newborn survival. It is recommended that IBI continue to receive support to professionalize the association and strengthen its ability to advocate for MNH services and better support its members to deliver quality care.

11. Better regulation, accreditation, licensure, quality assurance, and certification are needed for both the public and the private sector.

While the private sector is growing as a provider of MNCH care, the public sector still provides treatment for a significant number of poor patients, and is particularly important as a provider of community and public health programming. However, adherence to standards of practice within the public sector is variable at best, and little is known about quality in the private sector. Licensing requirements are largely check-list based and do not evaluate the quality of care. District governments need support to build their capacity to ensure effective regulation and quality assurance. Due to dual practice amongst midwives, there are significant externalities to building capacity within the public sector as an entry point, while taking complementary steps—such as working with national professional associations—to improve private sector care.

Similarly, for hospitals, greater efforts are required for regulation, quality assurance and certification. Ongoing supervision of clinical standards, including by use of clinical checklists, shows promise in a number of areas.

12. While the private sector is growing in importance as a provider of MNCH care, entry points for donor assistance are not always apparent. Any direct support should have a clear strategy for investment including realistic outcomes and a plan for exit.

As noted above, little is known about standards of care in private sector facilities, including private hospitals. Clarifying roles and responsibilities of government, professional organizations and providers (for example faith-based organizations) in regulating the quality of clinical care would be one possible approach for donor assistance.

While many more women are reporting delivering with private midwives, the reality is that the vast majority of midwives in Indonesia conduct dual practice. Efforts to improve the clinical practice of public midwives should improve private practice and vice versa.

In an effort to improve private midwifery practice, USAID has invested in IBI's *Bidan Delima* program over the past decade. The hope was that the *Bidan Delima* would become a self-sustaining franchise, and be managed autonomously from the professional organization. While the split of management was achieved under HSP support, the review of *Bidan Delima* as an organization showed that IBI did not see the program in the same terms as the donor. While both parties wish to emphasize the program as a mark of quality assurance, IBI sees the program as a 'moral movement' rather than a franchise business. There is also little evidence that the poor are patients of these private practices. Should USAID wish to continue to support the development of this program, a strategy that starts from IBI's conceptualization of *Bidan Delima* is required. With little hope for financial sustainability under current fee and service structures, USAID must be clear about the nature of its investment and on an exit strategy before further investments are made. Given that the service does not address the needs of the poor, it is recommended that any future support be separately procured from a broader MNCH program.

13. Future donor support should strengthen the role of hospitals in providing maternal and newborn care, particularly in cases of obstetric and neonatal emergency.

There are simply not enough obstetricians or neonatalogists to cover the Indonesian population. The HSP-supported QUAPEC study showed that the majority of hospital deliveries in rural areas are for emergency cases. The HSP-supported training of general emergency room personnel in dealing with emergency obstetric and neonatal cases shows a promising route to providing care in the face of such specialist shortfall. Training for this group should not be comprehensive but instead focus on the major maternal and neonatal diagnoses. This approach should be scaled-up nationally using regional training hospitals as the vehicle for both training and ongoing supervision.

As part of this approach, efforts should be made to improve both the physical capacity and overall management to address major deficiencies in the hospital environment.

14. Kangaroo Mother Care (KMC) should continue to be supported under any new programming, however considerations of a staged approach to implementation and scale-up are needed.

KMC is an effective and low-cost approach that could help to significantly reduce the large percentage of neonatal deaths attributable to low birth-weight in Indonesia. Future donor support should seek to strengthen activities in the hospitals that have begun to work with the KMC approach to ensure there is a functional model before considering a scale-up to other hospitals.

Hospital-based implementation should also be functioning before introducing community-based KMC. For KMC to work in the community, a continuum of care at the hospital must be in place. Implementing hospitals should also have a supervisory role over outpatient care, even if undertaken at the *puskesmas* or by a village midwife.

It is recommended not to continue a model of rapid scale-up across hospitals under the guidance of the professional groups. More consideration is needed to determine the most appropriate method for ensuring that implementation of the approach meets standards for quality of care. These considerations should also determine how to incorporate costs associated with KMC into routine health system budgets so that the introduction of KMC is not considered an imposition by hospital administrators.

Support should also be given to advocating for a new protocol for promoting the skin-to-skin position for transporting all newborns from home to healthcare facility and between health facilities. This should apply to all newborns and not just low birth-weight babies. Given the large numbers of trips undertaken by motorcycle, particularly in rural areas, the promotion of this protocol has the ability to save the lives of many newborns.

COMMUNITY

15. While international consensus is that community interventions have been overemphasized as the expense of clinical improvement, HSP experience shows that there is still a need to support community mobilization efforts in Indonesia.

The focus of this support should be targeted to specific messages, should target vulnerable groups, should strengthen existing community structures and should draw on locally available resources and funding.

16. Support should target specific messages and approaches.

Community mobilization efforts should not attempt to replace essential health services, but instead focus on key interventions that are within the purview of *kader* and other community stakeholders. The core of the effort is to work with *kader*, *bidan desa,* and traditional birth attendants to increase the number of deliveries by skilled birth attendants and the number of facility-based deliveries. As a part of this more work is needed on referral; the HSP-supported QUAPEC study showed that recognition of danger signs for obstetric and neonatal complications, and the appropriate pathways for referral, are low amongst the community. HSP supported additional training on this issue for communities, but future assistance should ensure that this is more carefully covered as part of the P4K package.

Kader were already familiar with active surveillance from immunization drives, but were introduced to an expansion of this approach to cover MNCH with HSP support. While the concepts were understood, ensuring routine application will require more time than was available under the HSP extension and good follow up and support by *bidan desa* and *puskesmas* staff.

Wherever possible, these activities should be introduced as strengthening existing mechanisms rather than as new activities, and should draw on existing skills and experience gained from other community-level activities.

17. While community activities can be taken to scale, a focus on the poor must be maintained.

The GOI has a special focus on poor, remote and lagging regions, and many district mirror this on a local scale. Support for this policy can help to reach the poorest communities, however donor support can also help districts to reach the most vulnerable, as community systems tend to be weakest in poor areas.

As well as targeting poor communities, reaching out to the most vulnerable within communities could show significant results. The HSP-supported QUAPEC study showed that the majority of emergency cases presenting at district hospitals were from poor, rural households and were the first pregnancy for the woman. There is global

evidence of the efficacy of pre-marriage counseling programs for improving reproductive as well as maternal, neonatal and child health. Future assistance should seek to strengthen existing community programs to reach these most vulnerable groups.

18. Existing community organizations and campaigns should be mobilized to lead community-level activities.

Earlier phases of HSP worked to establish community health committees, however the problem of sustainability presented itself. NGOs and religious organizations that had been HSP partners working at the village level were seeking ongoing funding in order to continue their support. In the final phases of HSP, agreements were made to partner with the PKK for support of P4K, active surveillance and *posyandu* activities. Not only does the PKK carry political clout—based on an assumption of male political power, the wife of the local official (for example, *Bupati*) is the *ex officio* head of the PKK at each level of the system—but funds are also allocated through district budgets. In conjunction with this approach, HSP also supported existing district health campaigns, or the MNCH elements thereof. In doing so, the support of the District Health Office and other district stakeholders is also brought into play. It is recommended that any future assistance similarly support existing local campaigns wherever possible.

HSP support focused on ensuring good collaboration between the PKK and other existing groups undertaking health activities in communities, encouraging a model of cooperation rather than duplication of activities. Involvement of the village midwife is critical. Part of the support was helping the PKK to prioritize the activities of the *Pokja IV* (the working group on health) within the PKK. HSP also supported training of nominated PKK members at the sub-district level to act as village committee facilitators. These facilitators can not only assist communities to sustain activities revitalized with HSP support, but can continue to facilitate groups in other villages in an effort to reach full district coverage of activities.

19. Efforts to garner local funding sources should be supported.

Through *musrenbang*, villages can press for allocation of village funding to support community health programs, and for prioritization of health and MNCH in the district budget. Other sources of funding exist at the community level which can be leveraged through local planning, such as PNPM, a national participatory planning program which provides block grants for village development projects, some of which include a focus on MNCH. Donor support should focus on providing counterparts and beneficiaries with the skills to leverage these sources over providing direct funding.

20. Further investments should be made to develop tools for guiding community level evidence-based planning.

HSP supported the development of tools to help communities to undertake evidence-based problem analysis and planning. These tools gave participants the means to conduct basic analysis of data generated in that village. Due to time constraints, these

tools did not undergo rigorous testing and were not adopted by the GOI. Feedback from HSP field staff and counterparts however, reported that these simple picture based guides were very helpful to low-literacy community members in conceptualizing health problems and linking the identification of problems with evidence-based solutions appropriate to community-level capacities.

With increasing funds available at the village level through sources such as the National Community Empowerment Program (PNPM) as well as other village block grants, guidance is increasingly important. It is not realistic to expect non-specialists to know what interventions will have the desired community health outcomes; these tools provide guidance on solutions while allowing communities to analyze their own situations and make their own priorities. The tools also functioned as an educational tool for communities for increasing understanding on MNCH.

21. Sustainability of community-level activities can be enhanced through the passage of MNCH *perdes*.

Village regulations give rise to a greater likelihood of sustainability in that they institutionalize a number of key provisions into local law. Typical aspects of the regulations included commitments to fund village-level MNCH activities (although envelopes were rarely stipulated). Also important was that many regulations established the role of the community health committee (or similar) in relevant aspects of village decisionmaking, including participating in village planning sessions including *musrenbang.* The process of passing a *perdes* also meant that a wider cross-section of stakeholders became involved in considering MNCH issues, which has proved useful when CHCs come to advocate for funding.

While HSP supported the development of a template for MNCH *perdes,* the template was suitably generic. Villages felt free to adapt the template to suit their own political priorities, while still following the general guidance on supporting MNCH.

Although villages are considered politically autonomous at the level of their authority, sub-districts and districts can still play a role in monitoring the implementation of *perdes.* HSP support encouraged complementarity between regulations, with each level defining the role of stakeholders within that sphere of influence.

22. Support for community-level planning should also provide CHCs with the relevant knowledge and skills to leverage funds from other sources, including the private sector and other GOI programs.

The tools and approaches that HSP supported to conduct analysis and planning for village level *musrenbang* proposals can assist communities to determine their own development agendas and to use available sources of funding to fill various gaps. The planning process is expected to assist with Ministry of Home Affairs calls for medium-term village development plans. The approaches are equally applicable for use in

PNPM planning, to the development of CSR proposals, and could also help communities to better dictate the terms of NGO support.

In the final stages of HSP, field staff facilitated meetings between the PKK Community Facilitators and Facilitators from the National Community Empowerment Program (PNPM). The potential for leverage is enormous. Eight of the 12 indicators for the Generasi sub-program are related to health outcomes. Other PNPM sub-programs are also relevant; one provides conditional cash transfers to poor families on the proviso of meeting selected health and education seeking behaviors, including child immunization; another provides general development funding that could be used for health if identified as a community priority.

ANNEX I - LIST OF HSP IMNCH MODEL TOOLS AND MODULES[22]

Human Resource Training Manuals for the Implementation of the MNCH Program

Title	Content
Training Manuals for Maternal and Neonatal Health Program	
APN Training Manual	APN standardization training manual for health provider attending normal deliveries in different levels of health facility.
PPGDON Guidelines	Training manual for standardization and implementation of First Aid to Obstetric and Neonatal Emergency for health providers
PONED Training Manual	Training manual for standardization and implementation of Basic Obstetric and Neonatal Emergency Services for health providers
PONEK Training Manual	Training manual for standardization and implementation of Comprehensive Obstetric and Neonatal Emergency Services
Practical Guide to Family Planning Services/CTU	Practical guidelines for FP services.
Practical Guide to Maternal and Neonatal	Practical guidelines for maternal and neonatal services.
Practical Guide to Infection Prevention	Practical guidelines to apply infection prevention practices.
Training Manuals for Maternal, Neonatal and Under-Five Health Program	
Neonatal Asphyxia Management (included in APN)	Training manual for standardization and implementation of asphyxia management on low birth weight infants for midwives
LBW Management	Training manual for standardization and implementation of LBW management for village midwives
IMCI	Book that provides guidelines to assess a sick younger-than-2-month-old baby and how to manage it.
Training Package on Integrated Management of Childhood Illness (IMCI) (Ministry of Health, Republic of Indonesia, 2008)	This package consists of several books for IMCH training and implementation: • Facilitator's guide to the IMCI Module • Module 1 Introduction • Module 2 Evaluation and Classification of sick children age 2 months to 5 years • Module 3 Determine Action and Administration of Medication • Module 4 Counseling for Women • Module 5 Integrated Management of Newborn younger than 2 months old • Module 6 Follow up • Book on Photo Collection • Book on Charts of the Integrated Management of Childhood Illness • Recording Forms

[22] List compiled July 2009.

Title	Content
Training Manuals for Maternal and Neonatal Health Program	
Relevant Training Manuals	
Behavior Change Communication Manual	Training manual for District Health Office staff to improve their capacity in behavior change communication.
IPC-C Training Manual	Guidelines on inter-personal communication and counseling for health providers.
Guide to the DTPS MNCH – MNCH Program Planning Process (Ministry of Health, 2008)	Training manual on planning and advocacy for the District Advocacy Team
Qualification and Accreditation	Guidelines for training and implementation of provider qualification and health facility accreditation.
Training Package on Supervision Supportive for Maternal and Child Health Program (Ministry of Health, Republic of Indonesia, 2008)	This package is a reference to conduct training on and implementation of supportive supervision for District MCH Program Managers and Midwife Coordinators, the head of *Puskesmas*, MCH Program manager and Midwife Coordinator at the *Puskesmas*. Supportive supervision applies to midwives in *Pustu*, village midwives, midwives in *Puskesmas Kelurahan*, and private practice midwives. The package consists of: • Reference for Maternal and Child Health Program Supportive Supervision • Handbook for participants of the MCH Program Supportive Supervision • Handbook for Trainers of the MCH Program Supportive Supervision • Reference for Management Information System (Software to process the MCH Data) • Checklist for *Puskesmas* with in-patient care, Supportive Supervision for MCH, FP, and Delivery Care Services • Checklist for *Puskesmas*, Supportive Supervision for MCH and FP Services • Checklist for *Polindes*, Supportive Supervision for MCH, FP, and Delivery Care Services
Manual on Community Mobilization for Participatory Development Planning (HSP and Yayasan Satu Indonesia, 2008)	Training manual for the Village Health Committee to increase community participation in health program planning, especially MNCH
Training Module on Community Mobilization for Maternal and Child Health Program (HSP, 2007)	This training module is developed for village facilitator to conduct need assessment and long-term planning together with the community. The book discusses the content of each session in the training: • The basics in community mobilization, • The phases of community mobilization • The skills and tasks of community mobilization officers, • The relationships between community leaders – Village Health Committee – Village midwife – *Puskesmas* staff, • community need assessment, • Long-term planning, • P4K components.

QUALITY ASSURANCE

Quality Assurance Guide to the Maternal & Child Health Program Implementation & Services

Title	Content
Guide to Maternal and Neonatal Health Program Implementation and Services	
FP Program Management	This book provides guidelines on FP program management.
Guidelines on Birth Preparedness and Complication Readiness with Sticker (Ministry of Health, Republic of Indonesia, 2009)	This book contains guidelines to implement the steps on P4K. It explains: • The background, objectives, benefits, target population, definition and legal foundation of the P4K with Sticker; • Implementation of the P4K with Sticker including program indicators, outputs of the P4K with Sticker, components of the P4K with Sticker, activity phases, the role of *Puskesmas*, midwife, TBA and MCH support group, and MCH support group workplan, • Way to monitor and evaluate P4K.
ANC Guide	A reference for providing antenatal care for pregnant women
MCH Book	Contains record of maternal health (pregnancy, childbirth, postpartum) and child (newborns, infants and under-five) health (growth and development). It also contains information on maternal and child health and how to maintain it.
Management guide to women's class	A guide to conduct women's class program. The activity is intended to give important knowledge to pregnant women so that they will have a clean and safe pregnancy and delivery.
Guidelines to Basic Midwifery Services based on Human Rights and Gender Fairness (Ministry of Health, Republic of Indonesia, Directorate General of Public Health, Directorate of Family Health, 2004)	This book is intended for midwives in providing antenatal services, delivery and postpartum care integrated under innovative approach by raising awareness of human rights and gender. It is revised to reflect the updated services standards. The book was developed based on the guidelines for Basic Midwifery Services adapted from the Healthy Mother and Healthy Newborn Care book of 1997 and 1998. The following are explained: • Midwifery services based on human rights and gender. • Midwife's leadership in the community containing leadership around reproductive health and rights, characteristics of effective leadership, and how to build midwife leadership capacity. • Communication skill in counseling. • Antenatal services (equipment, history taking, physical examination, need-based services, recording of antenatal service results). • Infection prevention covering objectives, definition and principles, infection prevention procedures, hand washing and use of gloves, application of aseptic techniques, and infection prevention outside an institution. • Delivery care covering the stages of the delivery process, maternal care during delivery, 1st, 2nd, and 3rd stage of labor, and childbirth services. • Postpartum care (changes to woman and baby and postpartum services).

Title	Content
Guide to Maternal and Neonatal Health Program Implementation and Services	
Midwifery Service Standards	This book contains information on standards in midwifery service provision.
Guidelines to STI Services in Integrated Reproductive Health	Guidance on how to manage sexually transmitted infection in women
Guidelines on Malaria Prevention and Management	This book provides guidance on how to manage malaria in pregnant women
Guidelines on PMTCT	This book provides guidance on how to maintain and manage the health pregnant woman who has HIV or AIDS infection to prevent infection to the baby in her womb.
Technical guidelines on Injection of Prophylactic Vitamin K1 for newborn	Guidelines to inject vitamin K1 prophylaxis to newborn for health providers
Guidelines on MPA	Guidelines to trace causes of maternal and neonatal morbidity and mortality. This tracking is important to avoid recurrence.
Guidelines to Develop Basic Emergency Obstetric – Neonatal Services (PONED) (Ministry of Health, Republic of Indonesia, 2004)	This book is used to develop and implement PONED in the district. This guidelines explain: • Policy on program development covering definition and criteria, person in charge, support from relevant parties, PONED distribution, and collaboration in provision of PONED services. • Steps to develop a PONED *Puskesmas* including preparation, implementation, recording and reporting, and monitoring and evaluation. • Program supervision covering aspects of supervision, organization, role of supervisor and supervision activities.
Guidelines on Maternal and Neonatal Referral System at the District Level (Ministry of Health, Republic of Indonesia, 2007)	This book is intended for health providers who manage and provide maternal neonatal health services. It explains the: • Definition of MPS as the strategies to accelerate reduction of MMR and NMR. • Maternal and Neonatal Referral System, covering maternal and neonatal referral problems, benefit an definition of the maternal and neonatal referral system, development of pre-hospital, referral path of emergency obstetric and neonatal services, development of 24-hour PONEK hospital, recording and reporting, monitoring and evaluation, quality assurance program, indicators, and community participation in maternal and neonatal referral system. • Development of maternal and neonatal referral system components including PONEK at the district hospital, PONED in *Puskesmas* and *Puskesmas* with in-patient, PONED at village health facilities. • Evaluation of performance including principles to measure performance, measurement of 24-hour emergency unit performance, and emergencies obstetric and neonatal services for patients.
Guide to Neonatal, Infant and Under-Five Health Program Implementation and Services	
Management guide to women's class	The MCH book contains record of maternal health (pregnancy, childbirth, postpartum) and child (newborns, infants and under-five) health (growth and development). It also contains information on maternal and child health and how to maintain it.

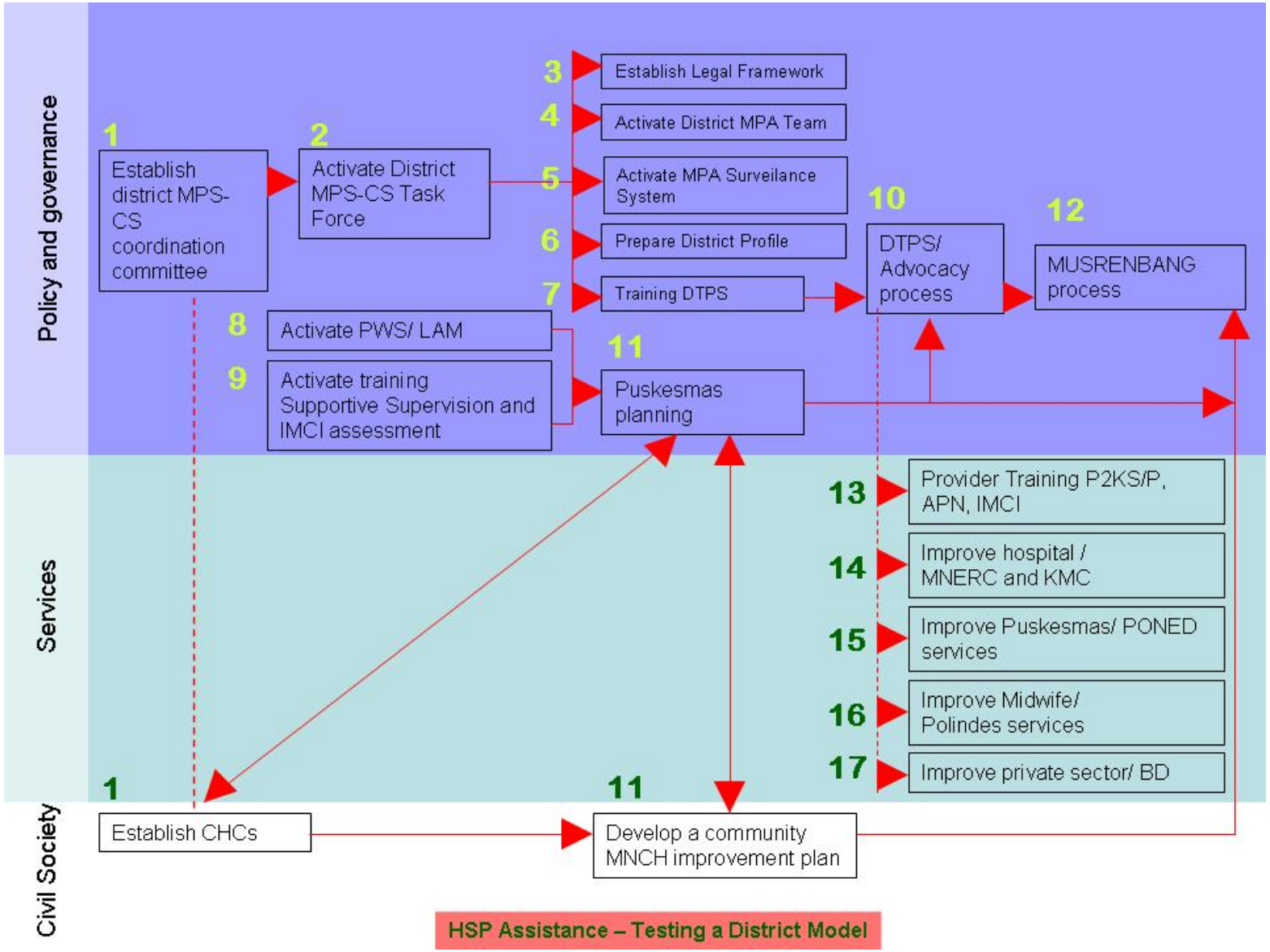
Title	Content
Guide to Maternal and Neonatal Health Program Implementation and Services	
Management guide to the class of women with under-five	This book provides guidance to manage a class for women with under-five. This activity is intended to provide the best information that women with under-five should know to be able to maintain and monitor her child's growth and development.
Training Package for Integrated Management of Childhood Illness (IMCI) (Ministry of Health, Republic of Indonesia, 2008)	IMCI is a management approach for sick under-five who come to a health facility. IMCI provides guidance for health provider to conduct comprehensive assessment of sick under-five to avoid mistaken in diagnosis and/or undiagnosed health problems. IMCI provides guidance on management of under-five for health problems based on assessment findings. The reference for IMCI is the book on Integrated Management of Childhood Illness charts and recording forms that is a part of the Training Package for Integrated Management of Childhood Illness.
Other Relevant Implementation Guidelines	
Guide on MCH LAM	A guide for the MCH program management to continually monitor coverage of the MCH services in an area for fast and appropriate follow up in areas with low MCH service coverage.
Guide on *Bidan Delima*	A guide for management and technical guidelines for implementing *Bidan Delima* Program in conjunction with the Pre-qualification tool, self-assessment, validation and facilitator's guide.
Implementation Guide for Deconcentration fund	A guide for the implementation of the MCH Program at the district using the Deconcentration fund

Reference for Monitoring, Supervision & Evaluation of the MNCH Program and Services

Title	Content
Reference for Supervision of the MNCH Program and Services	
Supportive Supervision of the Family Planning Services (Ministry of Health, Republic Indonesia, Directorate General of Public Health, Directorate of Maternal Health, 2006)	This manual explains the way to conduct supportive supervision on the FP services. It explains (1) integration of FP services into the health system, covering planning of the FP services and Recording and Reporting System for the FP services; (2) the main topics in supportive supervision that include definition, supportive supervisor, and connection between supervision supportive and quality assurance; (3) implementation of supportive supervision in FP services and (4) guide on how to fill in supportive supervision tool for FP services. This manual is intended for health providers who supervise FP services at the district and *Puskesmas.*
Manual for Medical Audit of the Family Planning Services (Ministry of Health, Republic of Indonesia, 2004)	This manual explains the objectives and methods for Medical Audit of FP Services (MPA-FP). The book explains (1) the objectives, target, operational definition, scope, influencing factors and strategies to implement the MPA-FP; (2) MPA –FP mechanism that includes principles and procedure of the MPA -FP;(3) steps to do the MPA –FP that include preparation, implementation, and monitoring and evaluation; and (4) Reporting and indicators. This book serves as a reference for FP providers at the district level, district hospital, *Puskesmas*, and village midwife.
Situation Analysis and Technical Guidance on FP Management Services (Ministry of Health, Republic Indonesia, Directorate General of Public Health, Directorate of Maternal Health, 2007)	This book simply discusses data on FP services to analyze technical guidance for FP service outlets in provincial and district levels. The book was developed for the FP service manager at the provincial and district levels to supervise quality of FP services at basic health services level. This book explains (1) type of FP service data and (2) technical guidance for data analysis that include analysis of data on performance and quality of FP services, analysis of supporting data, source of data, and activities to improve quality of FP services.
Package-I Self Assessment Tool: Tool to Measure Facility Performance (Directorate General of Public Health, Ministry of Health, Republic Indonesia, 2005)	This book contains guidance to use the self-assessment tool on (1) HR and physical structure, (2) facility management, (3) implementation of client-oriented principles, and (4) infection prevention efforts.
Package-II Self Assessment Tool: Tool to Measure Facility Performance (Directorate General of Public Health, Ministry of Health, Republic Indonesia, 2005)	This book contains instructions on how to use the self-assessment tool on (1) new FP client, (2) new FP pill user, (3) new FP injection user, (4) new IUD user, (5) new implant user, (6) combined oral continuing user, (7) progestin-only pill continuing user, and (8) follow-up visit of IUD user.
Maternal and Child Health Program Supportive Supervision Training Package (Ministry of Health, Republic Indonesia, 2008)	This book is not only intended for supportive supervision training, but also guidelines for conducting supportive supervision. Supportive supervision activities are carried out by the MCH program manager and midwife coordinator at the district level, head of the *Puskesmas*, and MCH program manager and midwife coordinator at the *Puskesmas*. Supportive supervision applies to midwives in *Pustu*, village midwives, *Puskesmas Kelurahan* midwives, and private practice midwives.

Title	Content
Reference for Supervision of the MNCH Program and Services	
Guidelines on Birth Preparedness and Complication Readiness with Sticker (Ministry of Health, Republic Indonesia, 2009)	This book contains guidelines to implement the steps on P4K. Chapter III explains the steps to monitor and evaluate P4K.
Guidelines to Develop Basic Emergency Obstetric – Neonatal Services (PONED) (Ministry of Health, Republic Indonesia, 2004)	This book explains the steps to develop PONED in the district. Chapter IIIC explains the reporting and recording and chapter IIID explains the steps on monitoring and evaluation that include monitoring, supervision and evaluation activities. And chapter IV explains the supervision for PONED that include organization, role of supervisor and supervision activities.
Guidelines for Monitoring, Supervision and Evaluation of Neonatal, Infant and Under-Five Health Program and Services	
Guidelines for Monitoring, Evaluating and Mapping of Integrated Management of Childhood Illness (IMCI) Application at the District and Province (Ministry of Health, Republic Indonesia, 2007)	The guidelines contain (1) background and objectives of training, post training monitoring, routine supervision, evaluation and mapping of IMCI application and (2) how to monitor, evaluate and map IMCI mapping that includes definition, objectives and target population, monitoring and evaluation tool and its use, and analysis of monitoring and evaluation results.
Other Relevant Monitoring and Supervision Guidelines	
Guide on MCH LAM	A guide for the MCH program management to continually monitor coverage of the MCH services in an area for fast and appropriate follow up in areas with low MCH service coverage.
Implementation Guide for Deconcentration fund	A guide for the implementation of the MCH Program at the district using the Deconcentration fund

ANNEX II – DISTRICT IMNCH MODEL



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Establish district MPS-CS coordination committee

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Establish district MPS-CS coordination committee (Nov)						
Political will and inter-sectoral cooperation needed to address MNCH problems Lack of high-level policy oversight of MNCH program to review data & take corrective action	Carefully select provincial/district partners Understand leadership capacity of PHO ID champions from legislative/executive	Multi-stakeholder meeting to establish district team, and facilitation to draft SK-Bupati (decision letter) Support for establishment of sub-district teams	MPS –SIG strategy MNCH Perda (district regulation) SK-Bupati (decision letter)	# of MNCH teams established at provincial and subdistrict level that meet quarterly	MPS-CS coordination committee established	Legal Frameworks Case Study & analysis of legal regulations Progress tracked through routine M&E presented in IMNCH report

Stakeholders Involved: Bupati, DPRD, PHO, DHO, Puskesmas, Kades, BPD

HSP Assistance – Testing a District Model << Back to

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Activate District MPS-CS Task Force

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Activate PWS/LAM (Oct-May)						
MPS-CS teams not active Political will and inter-sectoral cooperation needed to address systematic challenges Lack of high-level policy oversight of MNCH program to review data & take corrective action	Identify key decision makers in MNCH planning & management Build leadership capacity of DHO through inter-sectoral task force Engage champions from both legislative & executive	Support for formation and initial meetings of district team and sub-district teams TA to develop M&E indicators and identify team roles & responsibilities Field visits to monitor program implementation	MPS –CS strategy & guidelines IMNCH Guidelines MNCH law (Perda) SK-Bupati (decision letter)	# of MNCH teams established at district and sub-district level that meet quarterly	MPS-CS coordinat-ion committee established	Legal Frameworks Case Study & analysis of legal regulations Routine M&E and meeting reports

Stakeholders Involved: PHO, DHO, Bappeda, Sekda, Puskesmas, Private sector

HSP Assistance – Testing a District Model << Back to

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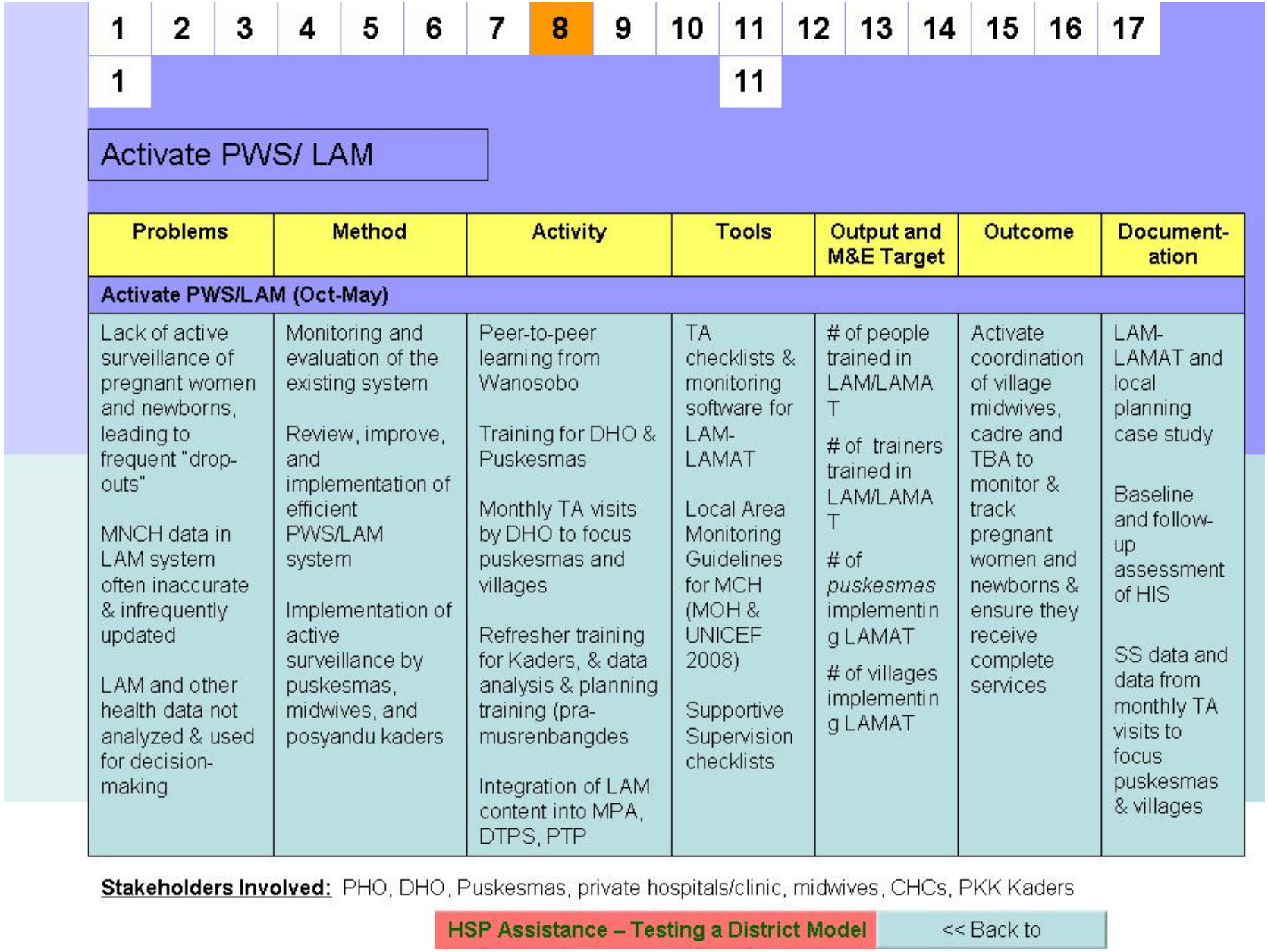
Activate training/ Supportive Supervision and IMCI

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Supportive supervision (Jan-Feb)						
SS Weak supervision system & quality monitoring by DHO for village & puskesmas programs IMCI Insufficient IMCI implementation, lack of data on IMCI availability for planning, lack of quality monitoring	SS Orientation supportive supervision and checklist, roll-out self assessment, and Q & A IMCI Orientation assessment tools, data collection, analyze data, provide action plan and advocacy to relevant stakeholders	Training of trainers Orientation Self assessment Verification Q & A	Supportive Supervision Guidelines and checklists, MOH 2008 IMCI Training Manual, MOH 2008 IMCI Assessment Tools, 2008 IMCI Guidelines, MOH 2007	# of service delivery points implementing QA/QI approaches # of people trained in maternal/new born health through USG-supported programs	Increase MCH services at the level of the polindes, private midiwves, and puskesmas	Supportive supervision checklists & data Routine M&E of program implementation

Stakeholders Involved: Polindes, Puskesmas, DHO, PHO, MOH

HSP Assistance – Testing a District Model << Back to



Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Activate PWS/LAM (Oct-May)						
Lack of active surveillance of pregnant women and newborns, leading to frequent "drop-outs" MNCH data in LAM system often inaccurate & infrequently updated LAM and other health data not analyzed & used for decision-making	Monitoring and evaluation of the existing system Review, improve, and implementation of efficient PWS/LAM system Implementation of active surveillance by puskesmas, midwives, and posyandu kaders	Peer-to-peer learning from Wanosobo Training for DHO & Puskesmas Monthly TA visits by DHO to focus puskesmas and villages Refresher training for Kaders, & data analysis & planning training (pra-musrenbangdes Integration of LAM content into MPA, DTPS, PTP	TA checklists & monitoring software for LAM-LAMAT Local Area Monitoring Guidelines for MCH (MOH & UNICEF 2008) Supportive Supervision checklists	# of people trained in LAM/LAMAT # of trainers trained in LAM/LAMAT # of *puskesmas* implementing LAMAT # of villages implementing LAMAT	Activate coordination of village midwives, cadre and TBA to monitor & track pregnant women and newborns & ensure they receive complete services	LAM-LAMAT and local planning case study Baseline and follow-up assessment of HIS SS data and data from monthly TA visits to focus puskesmas & villages

Stakeholders Involved: PHO, DHO, Puskesmas, private hospitals/clinic, midwives, CHCs, PKK Kaders

HSP Assistance – Testing a District Model << Back to

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
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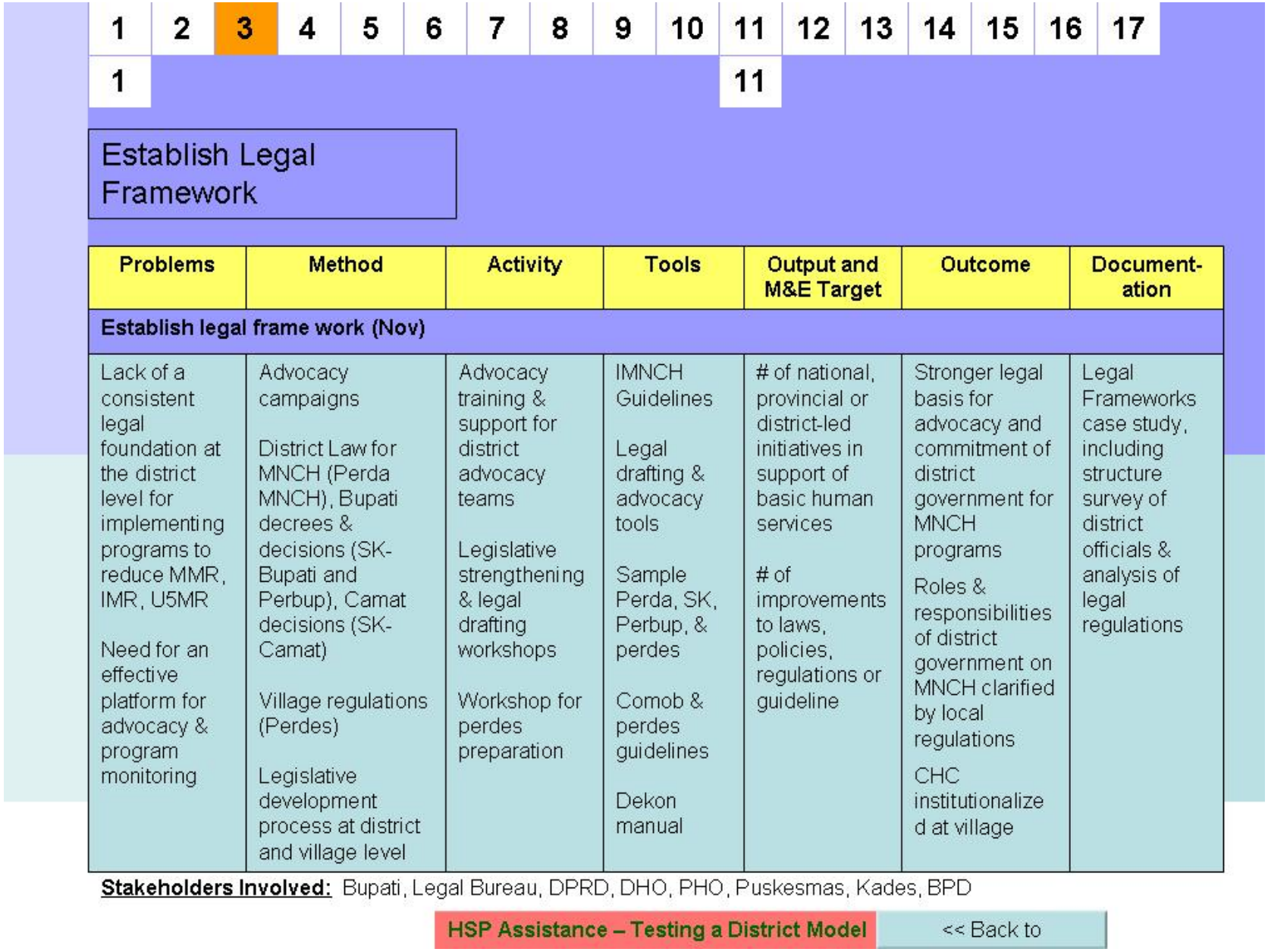
Establish CHCs

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Established CHCs (Oct)						
Community MNCH programs not being actively implemented Lack of institutional home for CHC Kaders not actively engaged in posyandu operation Lack of up-to-date data from village level	Expand coverage of CHC approach as a basis for P4K, GSI, Gemerlap Bersama Strengthen the role of the CHC in implementing and sustaining community MNCH activities	Implementation of P4K, GSI and Gemerlap Bersama Seed funds for community activities & formulation of Perdes (village regulations) Training of PKK Community Facilitators Cadre refreshing; training on LAM data analysis & planning (pra-musrenbangdes)	P4K & GSI guidelines Cadre refreshing guideline CF guideline BCC training manual & IEC training manual KADARZI Sample Perdes	# of (new) villages with Community Health Committees established # of Community Health Committees operational (to date)	Improved implementation of community MNCH programs Improved practices & behaviors (IBF, handwashing, birth preparedness, use of skilled providers)	Household survey Comob data Musrenbang observation Village budget data Analysis of village pra-musrenbang plans Routine M&E & tracking of Perdes

Stakeholders Involved: PKK, DHO, district government, KP3A, Camat, Puskesmas, midwives, village government

HSP Assistance – Testing a District Model << Back to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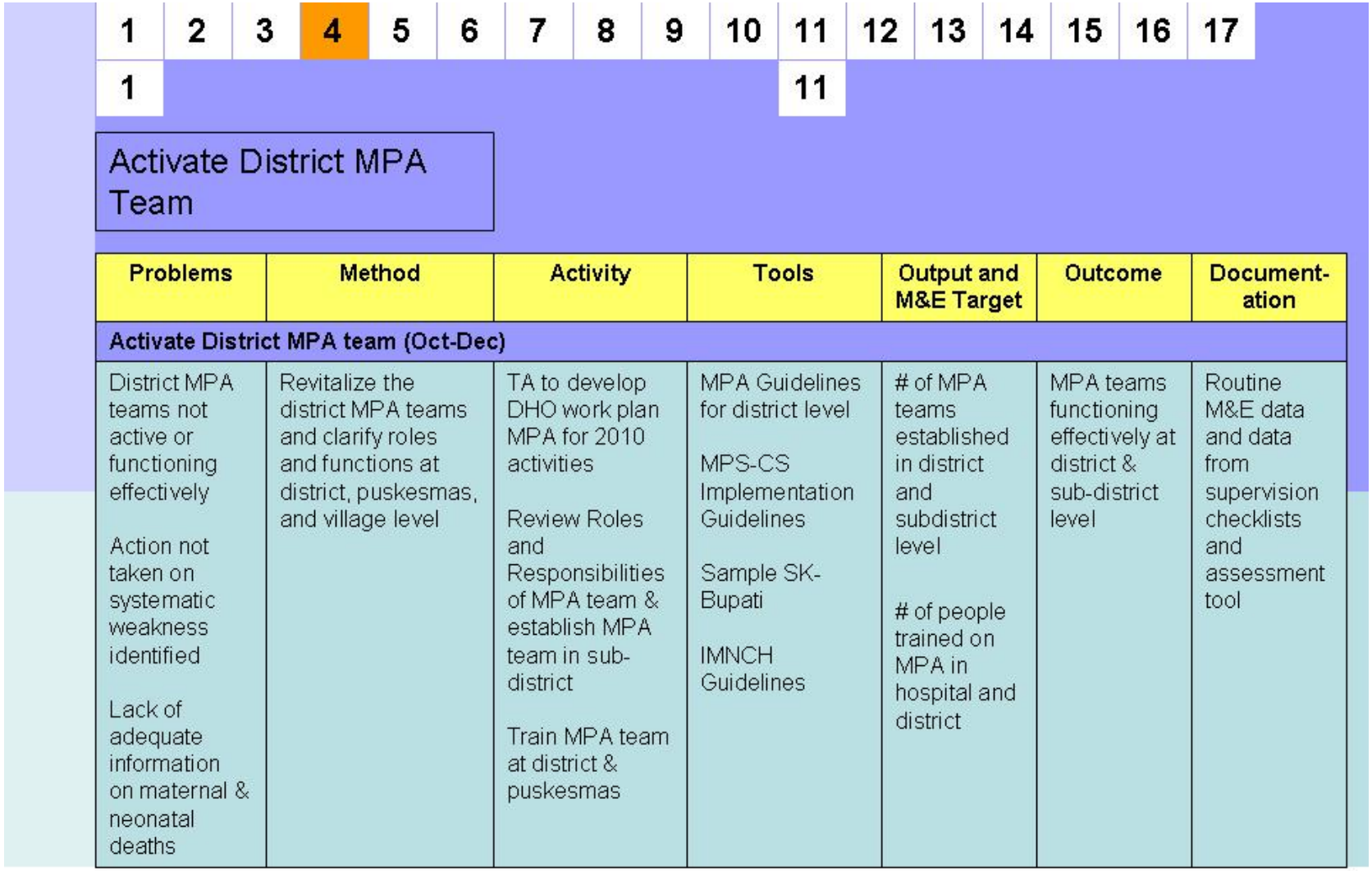
Establish Legal Framework
Problems
Method
Activity
Tools
Output and M&E Target
Outcome
Document-ation
Establish legal frame work (Nov)
Lack of a consistent legal foundation at the district level for implementing programs to reduce MMR, IMR, U5MR
Need for an effective platform for advocacy & program monitoring
Advocacy campaigns
District Law for MNCH (Perda MNCH), Bupati decrees & decisions (SK-Bupati and Perbup), Camat decisions (SK-Camat)
Village regulations (Perdes)
Legislative development process at district and village level
Advocacy training & support for district advocacy teams
Legislative strengthening & legal drafting workshops
Workshop for perdes preparation
IMNCH Guidelines
Legal drafting & advocacy tools
Sample Perda, SK, Perbup, & perdes
Comob & perdes guidelines
Dekon manual
# of national, provincial or district-led initiatives in support of basic human services
# of improvements to laws, policies, regulations or guideline
Stronger legal basis for advocacy and commitment of district government for MNCH programs
Roles & responsibilities of district government on MNCH clarified by local regulations
CHC institutionalize d at village
Legal Frameworks case study, including structure survey of district officials & analysis of legal regulations
Stakeholders Involved: Bupati, Legal Bureau, DPRD, DHO, PHO, Puskesmas, Kades, BPD
HSP Assistance – Testing a District Model
<< Back to



Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Activate District MPA team (Oct-Dec)						
District MPA teams not active or functioning effectively Action not taken on systematic weakness identified Lack of adequate information on maternal & neonatal deaths	Revitalize the district MPA teams and clarify roles and functions at district, puskesmas, and village level	TA to develop DHO work plan MPA for 2010 activities Review Roles and Responsibilities of MPA team & establish MPA team in sub-district Train MPA team at district & puskesmas	MPA Guidelines for district level MPS-CS Implementation Guidelines Sample SK-Bupati IMNCH Guidelines	# of MPA teams established in district and subdistrict level # of people trained on MPA in hospital and district	MPA teams functioning effectively at district & sub-district level	Routine M&E data and data from supervision checklists and assessment tool

Stakeholders Involved: Bupati, DHO, PHO, MOH, District Hospital, Specialist (Obgyn, pediatrician), Puskesmas

HSP Assistance – Testing a District Model << Back to

Activate MPA Surveillance System

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Documentation
Activate MPA Surveillance System (Jan-May)						
District MPA teams not active or functioning effectively Action not taken on systematic weakness identified Lack of adequate information on maternal & neonatal deaths	TA to DHO and MPA team to conduct MPA & verbal autopsy on all maternal and perinatal deaths Support for review of audit results & identification of follow up actions	Train MPA team at district & puskesmas Review of MPA results at district, sub-district, and village levels Review recording & reporting at district & sub-district Field visits for Verbal autopsy	MPA Guidelines for district level MPA Supervision Checklists & assessment tool for district, puskesmas & village level MPS-CS Implementation Guidelines IMNCH Guidelines	% of reported maternal and neonatal deaths reviewed by MPA team	Maternal and perinatal audits & verbal autopsy conducted for all maternal and perinatal deaths Follow-up actions identified and corrective actions taken	Results of audit review at district Data from supervision checklists and assessment tool

Stakeholders Involved: DHO, Hospital (RSUD), Puskesmas

HSP Assistance – Testing a District Model << Back to

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
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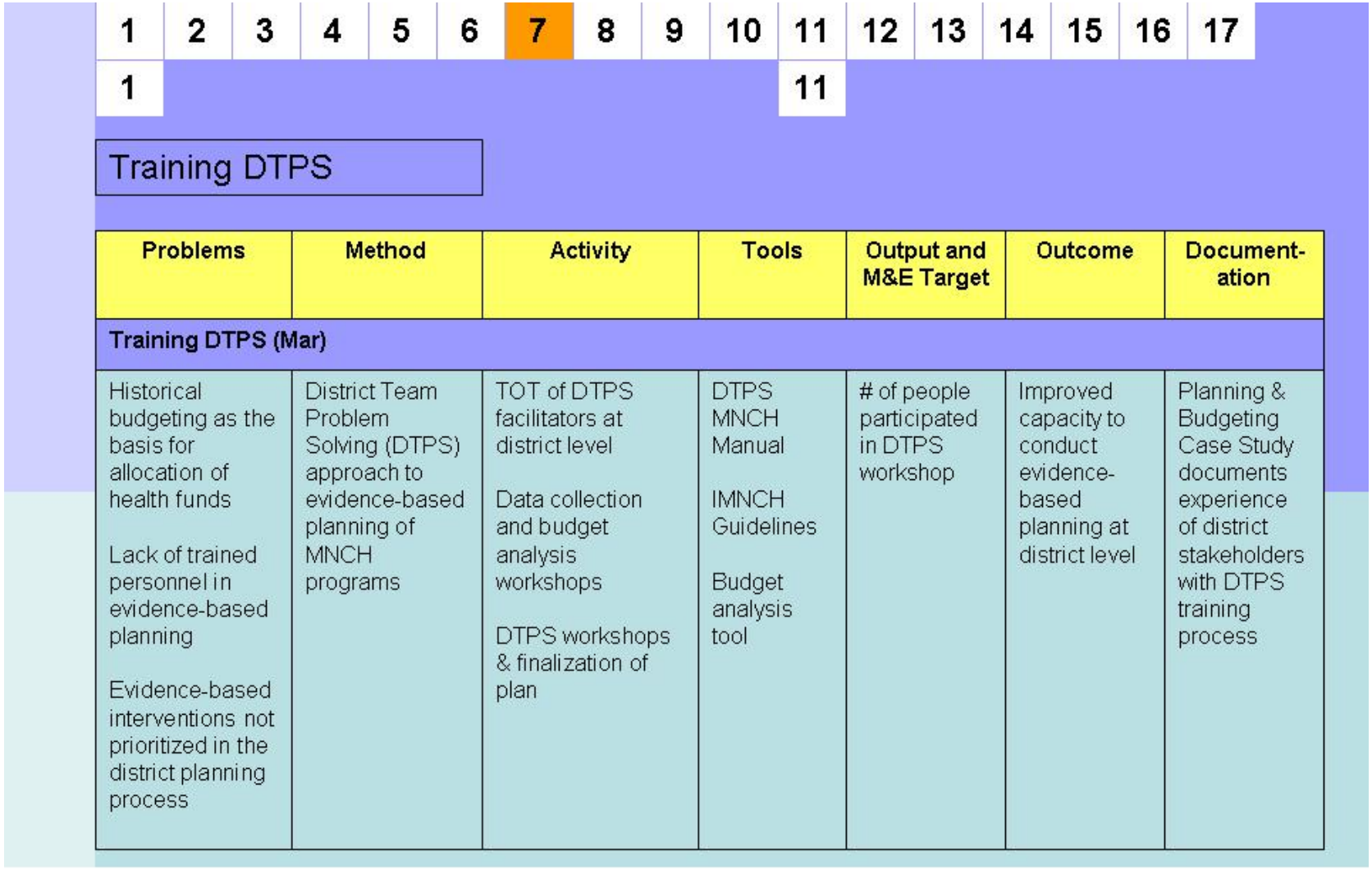
Prepare District Profile/ MNCH situation analysis

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Prepare District Profile/ MNCH situation analysis						
Lack of analysis of MNCH data from health information systems to inform decision-making at all levels	Improve analysis of LAM and other health data through DTPS and PTP Training of MPA team at district and sub-district level Training and supportive supervision for puskesmas and villages in collection and analysis of LAM / active surveillance data	Pre-DTPS and PTP workshops to undertake data collection Improve analysis & use of data through MPA and LAM-LAMAT, & SS Village planning (Pra-musrenbangdes)	DTPS MNCH & PTP Guidelines Supportive Supervision Guidelines MPA Guidelines Local Area Monitoring Guidelines for MCH (MOH & UNICEF 2008)	# of people participated in DTPS workshop % of reported maternal and neonatal deaths reviewed by MPA team	Accurate information and analysis of MNCH situation used as a basis for planning at all levels	Routline M&E of DTPS & PTP Analysis of village planning outputs

Stakeholders Involved: PHO, DHO, Puskesmas, private hospitals/clinic, midwives, CHCs, PKK Kaders

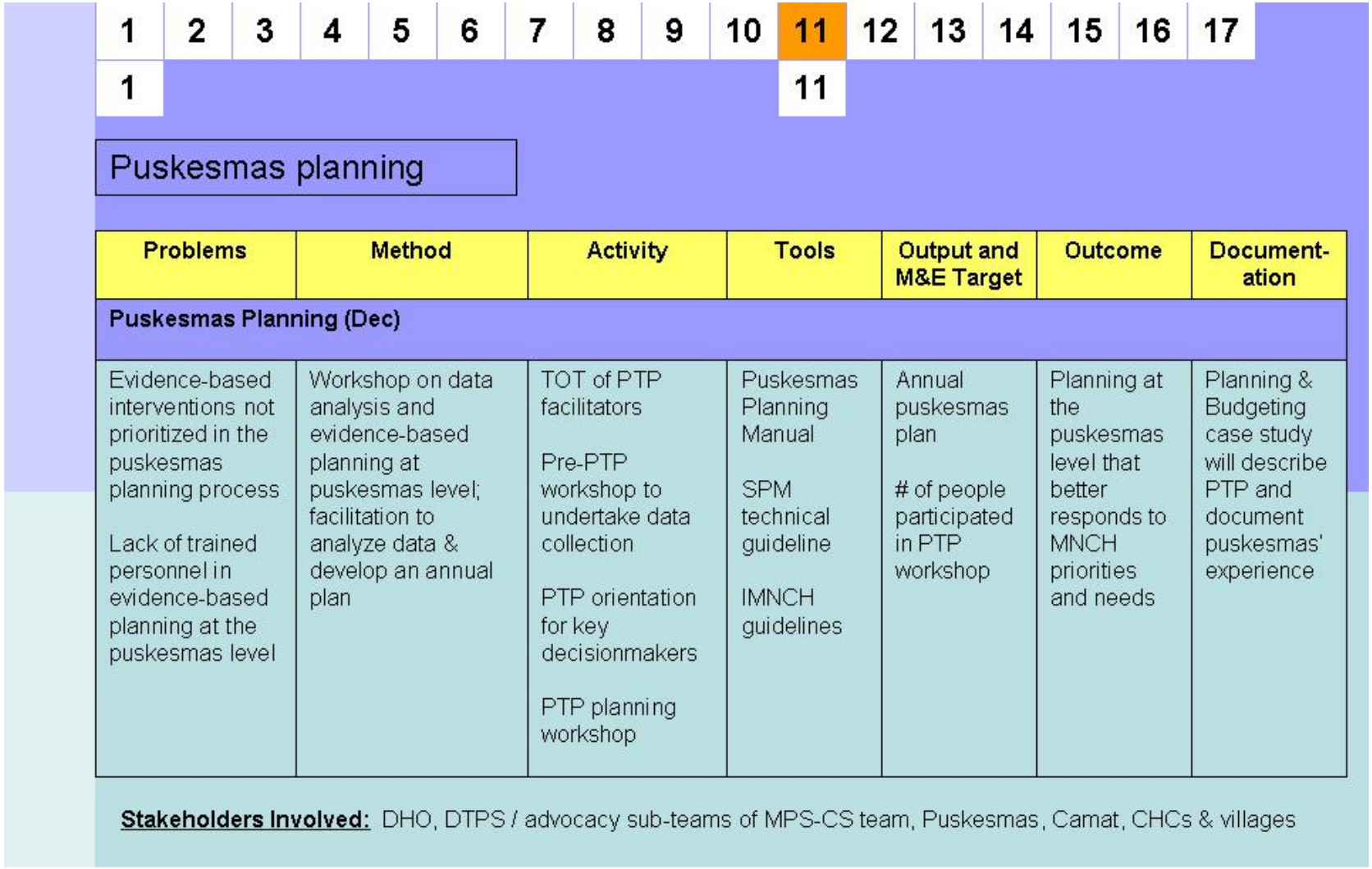
HSP Assistance – Testing a District Model << Back to



Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Training DTPS (Mar)						
Historical budgeting as the basis for allocation of health funds Lack of trained personnel in evidence-based planning Evidence-based interventions not prioritized in the district planning process	District Team Problem Solving (DTPS) approach to evidence-based planning of MNCH programs	TOT of DTPS facilitators at district level Data collection and budget analysis workshops DTPS workshops & finalization of plan	DTPS MNCH Manual IMNCH Guidelines Budget analysis tool	# of people participated in DTPS workshop	Improved capacity to conduct evidence-based planning at district level	Planning & Budgeting Case Study documents experience of district stakeholders with DTPS training process

Stakeholders Involved: DTPS team, MPS-CS advocacy team, Bappeda, Puskesmas, DPRD, DHO, NGOs

HSP Assistance – Testing a District Model << Back to



HSP Assistance – Testing a District Model << Back to

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Develop a community MNCH improvement plan

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Develop a community MNCH improvement plan (Dec-May)						
Community MNCH programs are not prioritized in village-level planning & many do not receive local funding Village lack experience and skills in performing basic analysis of local data & developing action plans	Facilitate basic data analysis & problem identification using data from posyandu & village midwives, including LAM-LAMAT Develop action plan & submit request to village planning forum (musrenbang-des) Develop village regulation on CHC role in planning	Pre-Musrenbang-des village planning activity Support to develop village regulations (Perdes)	Comob & Pre-musrenbang des guideline Perdes guidline & sample Perdes Musrenbang observation form	# of villages that receive HSP seed funds # of people trained on musrenbang (facilitator training) # of Perdes passed	Basic data analysis done at village level to identify problems Villages develop action plans based on problems Additional funding secured for community MNCH activities	LAM-LAMAT and local planning case study documents village experience with pra-musrenbang Observation of musrenbang Analysis of village plans and budget data

Stakeholders Involved: DHO, Bag Hukum, Pemdes, Sekda, Camat, Puskesmas, Bidan desa, CHC, village government

HSP Assistance – Testing a District Model << Back to

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
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DTPS/ Advocacy process

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
DTPS/Advocacy process (Mar)						
Key decision-makers are not aware of MNCH issues and do not prioritize MNCH programs or the results of DTPS planning Insufficient budget resources allocated for MNCH programs	Formation of district advocacy team and development of advocacy campaign Passage of district laws & regulations on MNCH Formation of the MPS-CS teams, and DTPS & advocacy sub-teams	Formation of advocacy teams and advocacy workshops District regulation (Perda) on MNCH, followed by executive decrees and regulations (SK-Bupat, SK-Camat, Perbup) Budget analysis, & advocacy of DTPS plans and results of PTP planning to key decision-makers	DTPS advocacy module Legal drafting tools Advocacy & policy presentation; stolen lives videos Budget analysis tool IMNCH guidelines	# Number of people trained in advocacy techniques	Key decision-makers supportive of MNCH improvement programs MNCH prioritized in the district budget (APBD)	Planning & Budgeting case study looks at DTPS/ advocacy contribution to planning & budgeting process, and stakeholder commitment Legal Frameworks case looks at contribution of MNCH regulations

Stakeholders Involved: DTPS team, Advocacy team, DHO, MPS-CS team, Bappeda, DPRD, Puskemas

HSP Assistance – Testing a District Model << Back to

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
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MUSRENBANG process

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
MUSRENBANG process (Nov)						
Lack of knowledge of health problems & planning approaches for MNCH at village level Lack of local funding for community MNCH activities (such as P4K) Lack of health sector participation in village planning forums	Participatory problem analysis and action planning at the village level, and development of proposals for musrenbang-des	Pra-musrenbang-des village planning activity PTP used as basis for puskesmas input for musrenbang at the sub-district	Comob & Pra-musrenbang Guidelines IMNCH Guidelines Musrenbang observation forms	# of people trained on musrenbang	Local funding secured to support community MNCH activities Community MNCH activities based on local problems	Observation of musrenbang LAM-LAMAT & local planning documents village experience with pra-musrenbang Planning & Budgeting case study looks at musrenbang influence at district level

Stakeholders Involved: Bappeda, DHO, DTPS & Advocacy team, BPM, Camat, Puskesmas, CHC, Bidan village gov.

HSP Assistance – Testing a District Model << Back to

Provider Training P2KS/P, APN, IMCI

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Provider training APN (Dec)						
Lack of trained and competent health providers Lack of internal and/or external supervision to address quality of care Low quality services of neonatal and children under-5th	Support for training or providers on key evidence-based programs and interventions, and on strengthening supervision and quality assurance	APN (Normal Delivery Training) & IMCI Competency Based Training On-the-Job training Q&A and Monev	Basic delivery care (APN) guidelines, teachers manuals, and evaluation / validation instruments IMCI Manual and Guidelines, 2007 IMCI assessment tools	# of people receiving obstetric and neonatal clinical training through PPP # of people trained in SS, IMCI, and APN	Improved MCH services at the village and puskesmas level and through private midwives	Routine M&E and reporting from 2006 – 2009

Stakeholders Involved: MOH, professional associations (JNPK, POGI, IDAI, PPNI, IBI), MOH, PHO, DHO

HSP Assistance – Testing a District Model << Back to

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
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Improve hospital Services (MNERC and KMC)

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Improve hospital services (KMC and MNERC Services) (Oct-May)						
Maternal and perinatal emergency services of low quality & not provided promptly, particularly in Emergency Departments Poor quality and lack of low-cost treatment options for low birth weight and premature infants	Assess and strengthen skills of hospital staff in management of obstetric and neonatal emergencies Improve coordination between obstetric, neonatal, and emergency departments to provide prompt care Introduce and scale up Kangaroo Mother Care at the hospital level	Study on Quality and Access to Maternal and Perinatal Hospital Care at the District Level (QUAPEC) Maternal and Neonatal Emergency Room Care (MNERC) activity and training through provincial teaching hospital (RSSA) Kangaroo Mother Care (KMC) training and implementation	PONEK (CEONC) training package, OJT, assessment tools, and protocols, MOH 2008 MNERC protocols, checklists and monitoring tools RSSA training materials KMC training materials, video, monitoring instruments.	# of people participated in KMC OTJ # of people participated in KMC OTJ % of low-birthweight infants that received KMC during program implementation # of participating hospitals that have integrated KMC into written policy # of people trained in MNERC # of people participated in MNERC OJT # of hospitals with updated procedures for treatment of emergency obstetric and neonatal cases	Increase MCH services at the level of the hospital, include for the Emergency Room Care	MNERC monitoring & OJT data KMC assessment M&E data on PONEK 2006 – 2009

Stakeholders Involved: PHO, DHO, MOH, District government, professional associations, district & teaching hospitals

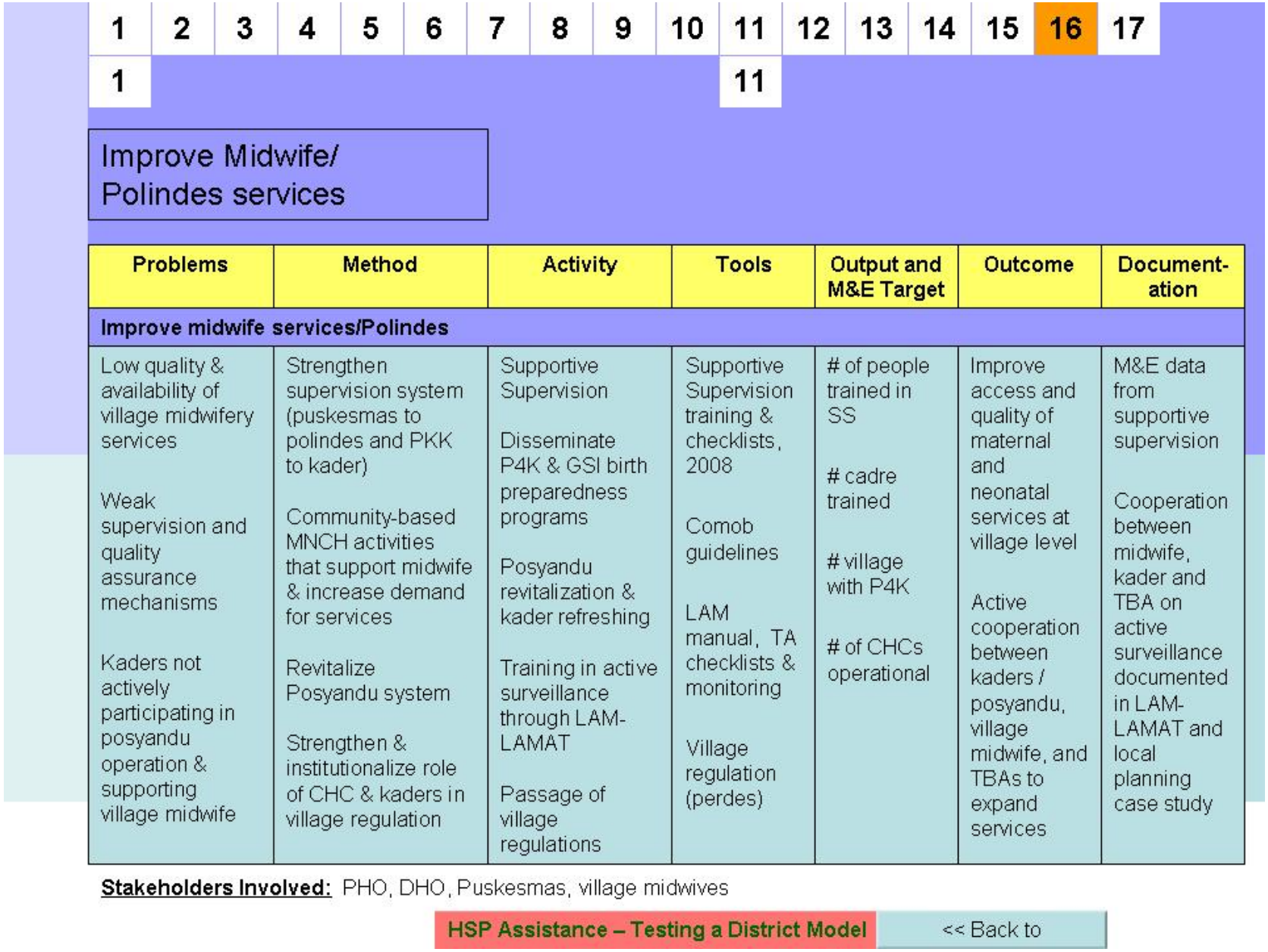
HSP Assistance – Testing a District Model << Back to

Improve Puskesmas/ PONED services

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Provider puskesmas						
Basic emergency obstetric neonatal services of low quality and low availability, particularly at the sub-district level Lack of investment in quality basic emergency obstetric & neonatal care (BEONC) at the puskesmas	Development of BEONC competency-based training, QnA and monitoring & evaluation of implementation	Review and update training package with MOH	PONED (BEONC) Training Package with reference book trainers guide, and participant guide, MOH 2008 Supportive Supervision training package	# of service delivery points implementing QA/QI approaches # of people trained in maternal/newborn health through USG-supported programs	Improved Basic Emergency Obstetric and Neonatal Care at the puskesmas level	M&E data from PONED 2007 - 2009

Stakeholders Involved: PHO, DHO, Puskesmas

HSP Assistance – Testing a District Model << Back to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Improve Midwife/ Polindes services
Problems
Method
Activity
Tools
Output and M&E Target
Outcome
Document-ation
Improve midwife services/Polindes
Low quality & availability of village midwifery services
Weak supervision and quality assurance mechanisms
Kaders not actively participating in posyandu operation & supporting village midwife
Strengthen supervision system (puskesmas to polindes and PKK to kader)
Community-based MNCH activities that support midwife & increase demand for services
Revitalize Posyandu system
Strengthen & institutionalize role of CHC & kaders in village regulation
Supportive Supervision
Disseminate P4K & GSI birth preparedness programs
Posyandu revitalization & kader refreshing
Training in active surveillance through LAM-LAMAT
Passage of village regulations
Supportive Supervision training & checklists, 2008
Comob guidelines
LAM manual, TA checklists & monitoring
Village regulation (perdes)
# of people trained in SS
cadre trained
village with P4K
of CHCs operational
Improve access and quality of maternal and neonatal services at village level
Active cooperation between kaders / posyandu, village midwife, and TBAs to expand services
M&E data from supportive supervision
Cooperation between midwife, kader and TBA on active surveillance documented in LAM-LAMAT and local planning case study
Stakeholders Involved: PHO, DHO, Puskesmas, village midwives
HSP Assistance – Testing a District Model
<< Back to

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
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Improve private sector/ BD

Problems	Method	Activity	Tools	Output and M&E Target	Outcome	Document-ation
Bidan Delima (Oct-May)						
Lack of regulation & quality assurance among private sector midwives Private sector midwives disconnected from district health information system Need for strengthening & sustainability planing for Bidan Delima program	Expansion of Bidan Delima program & recruitment of midwives through validation process Organizational capacity building for IBI to run Bidan Delima	Form management units in IBI chapters & revitalize BC units at province & dist. IBI organization assessment & strengthening BD promotion to the community Training and supervision (APN) for BD members Training in PPP, & monitoring CSR at district	Bidan Delima tools (self-assessment, validation & qualifcation instruments, facilitator's guide) PPP Training Module APN Training	# midwife members in *Bidan Delima* # of meetings with potential PPP partners # of people trained in PPP # of PPPs established Amount of funding leveraged from private organizations	Increased access to quality midwifery services Better reporting from private sector midwives	IBI Organizational Assessment M&E on Bidan Delima Program

Stakeholders Involved: DHO, IBI, Puskesmas, private midwives

HSP Assistance – Testing a District Model << Back to